GRACEPOINT HEALTH CENTERS/PRIMARY CARE
Authorization to Use and Disclose Protected Health Information

Patient's Name: _____ Dates of Treatment to Disclose: _____ ☐ All Dates

Address: _____
(Street) (City) (State) (Zip)

DOB: _____ SS#: _____ Phone: ( ) _____

I acknowledge and hereby consent to release information from my health record including medical, psychiatric and alcohol/drug abuse treatment information. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV or AIDS. I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of health information under CFR 45, CFR 42 Part 2, FS 394, 397, 381 and 90.503 cannot be disclosed without my written authorization unless provided for by the regulations.

Please check the information you want disclosed:

☐ Discharge/Continued Care Summary ☐ Physician Progress Notes
☐ Labs & X-Ray Results ☐ Pap smear
☐ Colonoscopy ☐ Mammogram ☐ Other (Please specify): _____

I authorize Gracepoint Health Centers to obtain from or disclose to or exchange with the individual or organization identified below:

Name/Provider: _____ Relationship: _____

Telephone/Mobile: _____ Fax Number: ( ) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Type of Disclosure: ____ Written ____Verbal ____Fax ____ Electronic E-Mail Address: _____

The information that I am authorizing for obtaining or disclosing or exchanging will be used for the following purpose:

☐ Continuity of Healthcare Treatment ☐Education ☐ Insurance/Disability ☐ Legal Reasons ☐ My Personal Records

This authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will automatically expire one year from the date signed

I understand the type of disclosure(s) authorized may be released past the date I sign until the expiration date of this authorization.

I understand that:

- I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at:
  - 2815 East Henry Ave., Suite D7, Tampa, Florida 33310 (I understand that the revocation will not apply to information that has already been disclosed in response to this authorization).
- If the requester or receiver is not a health plan or healthcare provider, then the disclosed information may no longer be protected by Federal Privacy Regulations and may be re-disclosed.
- I am entitled to receive a copy of this authorization.
- I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

I hereby release Gracepoint from liability which may arise as a result of information disclosed under this authorization if such information is later used to my detriment.

Signature of Patient/Guardian/Representative (circle one): _____ Date: _____

Signature of Patient's Legal Representative (if applicable): _____ Date: _____

If signed by Legal Representative, Relationship to the patient: _____

Proper documentation establishing relationship is provided (specify documentation): _____

Signature of Witness: _____ Date: _____

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