Andrews Institute ASC, LLC
1040 Gulf Breeze Pkwy., Suite 100
Gulf Breeze, FL 32561
Phone: 850-916-8524
Fax: 850-916-8519
Email: krainwater@andrewsinstitutesc.com

Authorization for Release of Protected Health Information

PATIENT ID:_____

Patient Name: _____
(Last) **(First)** **(Middle**

SS#: _____ **Date of Birth:** _____ **Telephone #:** _____

I hereby authorize the following person / entity:

ANDREWS INSTITUTE ASC, LLC / MEDICAL RECORDS
(Name of Entity / Individual / Class of Persons

1040 GULF BREEZE PKWY., SUITE 100
(Address)

GULF BREEZE, FL 32561
(City / State / Zip)

Release to:

_____
(Name of Entity / Individual / Class of Persons)

_____
(Address)

_____
(City / State / Zip)

2. I authorize the following types of information to be released:
___ General Medical ___ HIV/AIDS (May not apply to Labs) ____ Substance Abuse ___ Psychiatric ___ Psychotherapy Notes

3. I authorize the following types of records to be released: (check all that apply)
___ Face Sheet ___ Discharge Instructions ___ History & Physical ___ Pathology ___ Itemized Billing
___ Operative Report ___ Labs ___ EKG Other: _____

4. I authorize the following date(s) of service to be released: _____

5. This information is needed for the following purpose(s)
____ Continued Care ____ Insurance Claim ____ Personal Use ____ Legal Purposes Other: _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Facility Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** If I fail to specify an expiration date, event, or condition, the authorization will expire within **90 days**.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal or State Privacy Laws. If I have questions about disclosure of my protected health information, I can contact the BHC Privacy Officer at (850) 434-4472. I also understand that obtaining medical information under false pretenses is a Federal and State crime, punishable by up to 10 years in prison.

8. If present, alcohol and drug abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations 42CFR, Part2, prohibit making any further disclosure of records without the specific written authorization of the person to whom it pertains or as otherwise permitted by law.

MODE OF TRANSMISSION: Mail:___ Pickup Date:_____ Fax No: _____ Email Address: _____

CONFIDENTIALITY NOTICE - The information contained in this transmission is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. If you are not the intended recipient of this information, do not review, re-transmit, disclose, disseminate, use, or take any action in reliance upon, this information. If you received this transmission in error, please contact the sender or contact the AIASC Health Information Management Department at 850-916-8524 for further instruction.

_____ _____
Signature of Patient or Legal Representative **Date**