verIMED Health Group
Riverview
9366 Balm Riverview Rd. Riverview, Fl. 33569
Office (813) 672-3200 Fax (813) 672-3202

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: _____ Social Security #_____

Address: _____
Street City State Zip Code

INFORMATION TO BE RELEASED FROM:

Facility: _____

Address: _____
Street City State Zip Code

INFORMATION TO BE RELEASED TO:

Facility: _____

Address: _____
Street City State Zip Code

INFORMATION TO BE RELEASED (PLEASE CIRCLE)

Office Notes
Laboratory/pathology Reports
Radiology Reports/Imaging/X-ray
EKG/Monitors
Other_____

PURPOSE OF DISCLOSURE (PLEASE CIRCLE)

Changing Physicians
Insurance
Consultation/Second Opinion
Continuing Care
Legal Other_____

I understand that the information in my medical record may include information relating to treatment of drug and alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

I understand that I have a right to revoke this authorization at any time by notifying *veriMED Health Group – Riverview* in writing. I understand that revocation will not apply to the information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclosure of private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Printed Name: _____ Signature_____ Date_____
(Patient or Authorized Representative)