Patient Name _____ **Date of Birth**_____
Last First Middle initial

Home Address_____

_____

Phone # _____ **Date of Service**_____

Specify Information to be Disclosed: write or check below

Brief Description of PHI Disclosed: (Check one, or all that apply)	□ Facesheet □ Discharge summary □ Entire medical record □ Lab test results, specify: _____ □ Radiology results, specify: _____ □ Other, specify: _____	□ History or physical examination □ Consultation □ Emergency record of treatment

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization: (May waive this section if not pertinent)

□ Mental Illness _____
□ Developmental Disability _____
□ Psychotherapy Notes _____
□ HIV/AIDS Testing or Treatment (regardless of result) _____
□ Venereal Disease _____
□ Abuse of an Adult with a Disability _____
□ Sexual Assault _____
□ Child Abuse or Neglect _____
□ Drug / Alcohol _____
□ Genetic Testing _____
□ Other _____

RECIPIENT: **Name of person or class of persons to whom WEST BOCA MEDICAL CENTER may disclose my health information:**

Name: _____
Address: _____

Phone:_____

Fax:_____

PURPOSE: I authorize WEST BOCA MEDICAL CENTER to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:

_____

Please turn over and complete back portion

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

WEST BOCA
Medical Center

I understand that once WEST BOCA MEDICAL CENTER discloses my health information to the recipient, WEST BOCA MEDICAL CENTER cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that WEST BOCA MEDICAL CENTER may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at WEST BOCA MEDICAL CENTER; except, however, if my treatment at WEST BOCA MEDICAL CENTER is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case WEST BOCA MEDICAL CENTER may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to West Boca Medical Center Privacy Office at the address listed below. The revocation will be effective immediately upon West Boca Medical Center receipt of my written notice, except that the revocation will not have any effect on any action taken by WEST BOCA MEDICAL CENTER in reliance on this Authorization before it received my written notice of revocation.

For questions regarding copies of your medical records, please call 561-488-8342 (office) or 561-488-8338 (fax)

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize WEST BOCA MEDICAL CENTER to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient **Date/Time**

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Personal Representative **Description of Authority** **Date/Time**

☐ An interpreter was used to obtain this consent _____(name of service used)

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____ _____ _____
Signature of employee validating identity Date Time