

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Release Information to: Burke Blue Hutchison Walters & Smith, P.A.

Address: 221 McKenzie Avenue, Panama City, Florida 32401

Reason for Release: Legal purposes

Patient Name: _____ Date of Visit: _____

SSN: _____ Date of Birth: _____ Phone # _____

Requestor Name: William S. Henry

Please Initial all Appropriate Blanks:

____ Medical Record Abstract (Includes face sheet, Discharge Summary, History & Physical, Operative, Radiology and Pathology reports)

____ X-ray reports ____ Surgical Procedure report ____ Medication Record

____ Laboratory reports ____ Physician Progress Notes ____ Entire Medical Record

____ Consultation reports ____ Nursing Notes ____ Other: Billing

I understand that this release may include information relating to Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), treatment for drug or alcohol abuse, mental or behavioral health or psychiatric care. Any release of this information must be pursuant to 42 CFR and other Florida Statutes.

I understand that the facility may charge a fee for the costs of copying, mailing and other supplies associated with this request as authorized by Florida Statute 395.3025.

I authorize The office of Burke Blue Hutchison Walters & Smith, P.A. to pick up my records.

I understand that this information is protected under federal law and I have the right to revoke this authorization in writing. I understand that this consent is revocable upon written notice to the provider, unless action has been taken on this authorization. This authorization shall remain in force until close of case in order to effect the purpose for which it is given. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. I also understand that I may refuse to sign this authorization. Release of this information may be in several different forms, including verbal, written, audio, or electronic media (i.e.: fax, U.S. mail, FedEx, courier, etc).

Signature of Patient

Printed Name of Patient

Date

Patient Representative

Relationship to Patient

Date

Witness

Date