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: _____

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 ____ Medical Billing

_____ Other: _____

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 may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I understand that this consent is revocable by me at any time upon written notice to the provider, unless action has been taken on this authorization, and that this authorization shall remain in force until close of case in order to effect the purpose for which it is given. 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). If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain copies of any items produced and a copy of this authorization after I sign it, upon request.

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date
_____	_____	_____
Patient Representative	Relationship to Patient	Date
_____	_____	
Witness	Date	