**Medical Record Number**_____**(office use only)**

**BACH & GODOFSKY INFECTIOUS DISEASE**
**6010 POINTE WEST BOULEVARD BRADENTON FL 34209**
**TELEPHONE: (941) 746-2711 FAX: (941) 746-3433**

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

**Patient Identification**

**Patient Name**:_____ **Date of Birth**: _____

**Social Security #:**_____**Telephone #:** _____

**Address:** _____

**Purpose of Request**
**___Continued Care ___Insurance Claim ___Personal Use ___Attorney Review ___Other**_____

**I, the undersigned, authorize *Bach and Godofsky Infectious Diseases to***

**____RELEASE PROTECTED INFORMATION TO ____OBTAIN PROTECTED INFORMATION FROM**

_____ _____
**Organization** **Fax #**

**concerning the patient identified above, in accordance with state and federal laws.**

**Specific Information to be Disclosed/Period of Health Care**
The following information is to be disclosed: (Please check each item requested)
_____Complete Records _____ Physician Notes _____ Insurance Information _____Billing Records
_____ Lab/Culture Results _____ Operative Reports _____ X-ray Results _____Psychology Notes
_____ Radiology Results _____ Home Health Records _____Other _____
For the Following Date(s) of treatment or medical condition: _____

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIV/AIDS Records Release**
With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or HIV/AIDS related illness/testing and communicable diseases to be released unless otherwise specified here:
_____
_____

***Redisclosure*:** I understand that any disclosure of information carries with it the potential for redisclosure and the information then may not be protected by federal confidentiality rules.
***Right to Be Revoked*:** I understand that I have the right to revoke this authorization at any time. I understand my revocation must be I writing and will not apply to information already released.
***Fee:*** I understand there may be a fee to process this release of information.
***Other Rights*:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. If this authorization is needed for participation in a research study, my enrollment in the study may be denied. I understand I may inspect or obtain a copy of this information to be used or disclosed.
***Indemnification:*** I hereby agree to indemnify and hold Bach and Godofsky Infectious Diseases, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel, or slander, or defamation arising from or related to disclosure of such information.
***Expiration:*** Unless otherwise revoked, this authorization will expire in 12 months.

_____ _____
**(Patient or Patient's Legal Representative's Signature)** **(Date)**

_____ _____
**(Relationship if Other than Patient)** **(Witness)**

**Reason Patient is Unable to Sign: ____Minor ____Deceased**
**____Other:**_____