

Langheier Healthcare
P.O. Box 1287
Tarpon Springs, Fl. 34688
Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____

Information Requested From: _____

Recipient of Information: _____ Self _____ Other _____

Address: _____

Phone #: _____

Fax#: _____

Information To Be Disclosed:

- All Patient intake data/patient history.
- All Doctor's and Nurse's notes, memos, phone messages, or other such documents.
- Office notes and records of office visits.
- All reports containing opinions, diagnosis, recommendations, or evaluations of the patient's medical condition, prognosis, disabilities, future medical needs, limitations, or ability to work.
- Records from other Health Care Providers.
- Diagnostic and lab test results, as well as, reports interpreting such tests or data.
- All Correspondance
- X-ray, CT Scan, Myelogram, bone scan, and/ or MRI reports or results.
- Any psychological testing reports and results.
- Information related to HIV tests and results.
- Financial Statement

Purpose of Disclosure

- Continuing care with another physician or hospital
- Personal Copy
- Other: _____

Authorization

I Understand that:

1. This authorization will remain in effect for 1 year.
2. I may revoke this authorization at any time in writing, but if I do , it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that is strictly voluntary.
4. My treatment, payment, enrollment, or eligibility for benefits may not be conditiones on signing thisk authorization.
5. If the requestor or receiver is not a health plan or health care provider, the release of information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I may see and obtain a copy of the information described on this form, for any reasonable copy fee, If I ask for it.
7. I will receive a copy of this form.I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I also acknowledge I have reas the above and authorize the disclosure of the protected health information as stated.

Patient/ Guardian
Signature _____

Date _____

Patient/ Guardian
Printed Name _____

Relationship to Patient

Witness Signature _____

Date _____