Authorization for Release of Patient Information

Patient Name ____ Date of Birth ___________________________________

I hereby authorize:

Name	Address	City	State	Zip

Telephone Number Fax Number

to disclose the above named individual's health information as described below:

Description of Information to be released: (check all that apply)

____ Most recent history and physical
____Consultations
____ Radiology/Imaging reports
____ Radiology films
____Other ____
____ Laboratory reports
____ Progress notes
____ Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HTV"), behavioral or mental health, alcohol /drug(substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization:

David W. Frasure D.C.
1342 Timberlane Road, Suite 102B
Tallahassee, FL 32312
Phone: (850) 224-4268 **Fax:** (850) 727-0025

Description of the purpose of the use and/or disclosure:

____ Continuing Care
____ Consultation
____ Legal purposes
___Second Opinion
___Insurance
___Personal Use
__Social Security/Disability

Other: Please describe: ____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until ____________________________ (date or event).

I understand I may revoke this authorization at any time by notifying the HIPPA Compliance Officer at the office of Dr. David Frasure, 1690 Raymond Diehl Rd, Suite B-3, Tallahassee, FL 32308. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. This authorization is given pursuant to Florida Statute 456.057 and HTPAA regulations. I understand that Florida Statute 456.057(10) makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed consent of the patient or the patient's legal representative.

____ ____
Signature of Patient or Patient's Legal Representative Date

____
Printed name of Patient or Patient's Legal Representative

____ ____
Relationship to Patient or Legal Authority (attach supporting documentation)

____ ____
Signature of Witness Printed name of Witness