# The Health Associates of Tampa

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

| | |
|---|---|
| Patient's Name: | |
| Date of Birth: | Social Security #: |
| Patient's Address: | |
| City, State, Zip: | Phone: |

***I authorize the following entity:***

| |
|---|
| Entity: |
| Address: |
| City, State, Zip: |
| Phone: |

***To release my confidential Protected Health Information (PHI) to:***

The Health Associates of Tampa
508 S Habana Ave Suite #300 ● Tampa, FL 33609 ● Phone: (813) 877-6770 ● Fax: (813) 877-6771

The PHI to be disclosed is relevant medical records and reports relating to my medical treatment, consultation and/or examination. I understand the information disclosed based on this authorization may include mental health treatment, records and information regarding HIV/AIDS status, treatment and/or testing.

ADDITIONAL AND/OR SPECIFIC REQUEST:

_____

_____

I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke the authorization in writing. I understand that such revocation will not have any effect on any information already used/disclosed by THAT prior to our office receiving written notice of revocation. I also understand that the information disclosed under this release is subject to re-disclosure by the recipient and is no longer subject to protections of HIPAA. Treatment or payment for treatment cannot be conditioned on this authorization, except as allowed in the Privacy Rule.

I understand this authorization is in effect for 1 year from my signature date.

My signature below indicates that I have read and understand the authorization and its terms.

_____ _____

Signature of Patient Date