AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations		
Patient Name:	Birth Date:	Social Security No. *(optional)*:
Provider:	Address/City/State/Zip	
Recipient: **Winters & Yonker, P.A.**	Address/City/State/Zip **Post Office Box 3342 Tampa, FL 33601**	
This authorization will expire on the following: (Fill in the Date or the Event, <u>but not both</u>.) Date: Event:		
Purpose of Disclosure:		
Is this request for psychotherapy notes? □ Yes, then this is the only item you may request on <u>this</u> authorization. □ No, then you may check as many items below as you need.		

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
□ All PHI in record □ History and Physical □ Consult Report □ Operative Report □ Progress Notes		□ Physician Orders □ Laboratory □ Imaging/Radiology □ ER Information □ Medication Record		□ Itemized Bill □ Rehabilitation Services □ Special Test/Therapy □ Other:_____ □ Other:_____	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here □

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. 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 re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.
6. **My health plan may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.**
7. **A PHOTOCOPY OF THIS AUTHORIZATION IS AS VAILD AS THE ORIGINAL.**

Section B: Is the request of PHI for the purpose of marketing? **If yes, the health plan or health care provider must complete section B, otherwise skip to section C.**	
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?	□ Yes □ No
If yes, describe:	

Section C: Signatures	
I have read the above and authorize the disclosure of the protected health information as stated.	
Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: