

**Advance Preventive Medicine  
1400 E Robinson Street  
Orlando FL 32801**

**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE  
OF HEALTH INFORMATION**

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**I. My Authorization**

I authorize the following using or disclosing party:

\_\_\_\_\_

**to use or disclose the following health information.**

- All of my health information
- My health information relating to the following treatment or condition:

\_\_\_\_\_

- My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

- Other: \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name (or title) and organization \_\_\_\_\_

Address 1400 E Robinson street Orlando FL 32801 ( Advance Preventive Medicine )

Phone 407-845-8623 Fax 407-845-8667 Email apmucor@gmail.com

**The purpose of this authorization is (check all that apply):**

- At my request
- Other:
- To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.



**This authorization ends:**

- On (date) \_\_\_\_\_

- When the following event occurs: \_\_\_\_\_

**II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient:** \_\_\_\_\_

Date: \_\_\_\_\_

**If the patient is a minor or unable to sign, please complete the following:**

- Patient is a minor: \_\_\_\_\_ years of age

- Patient is unable to sign because: \_\_\_\_\_

**Signature of Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Print Name of Authorized Representative: \_\_\_\_\_

Authority of representative to sign on behalf of the patient:

- Parent    - Legal Guardian    - Court Order    - Other: \_\_\_\_\_

**III. Additional Consent for Certain Conditions**

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.

- I do not consent to have the above information released.

**Signature of Patient or Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

**IV. Additional Consent for HIV/AIDS**

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- I consent to have the above information released.

- I do not consent to have the above information released.

**Signature of Patient or Authorized Representative:** \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_