HIPAA Privacy Authorization Form

Request for Release of Medical Records

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Authorization

Printed name of patient or personal representative and relationship to patient

_____ Date _____/_____/_____

I authorize _____ (healthcare provider) to release and disclose the protected health information described below to:

Gary L. Clayman, D.M.D, M.D., F.A.C.S.
Clayman Thyroid Cancer Center
2352 Creel Lane
Wesley Chapel, FL 33544
Phone: 813-940-3130
Fax: 813-315-6360

Effective Period

This authorization for release of information covers the period of healthcare from:

_____ to _____ OR _____ All dates of service

Extent of Authorization

I authorize the release of all records listed below:

***CD of all X-ray and scans**
***Pathology slides/reports from any biopsies or surgeries**
***All lab reports**
***Doctor's office/hospitalization records**
*** X-ray/scan reports**

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Patient Name:_____**D.O.B.**____/____/____

Signature of patient or personal representative: _____

Phone Number:_____