AUTHORIZATION FOR NONROUTINE DISCLOSURE OF PROTECTED HEALTH INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: The McGregor Clinic, Inc **Phone #:** (239) 334 –9555

Address: 3487 Broadway, Fort Myers, Florida 33901 **Fax #:** (239) 334 – 2832

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s)
_____ History and Physical Results
_____ Progress Notes
_____ Diagnostic Test Reports (Specify Type of test(s) _____)
_____ Other: (specify)_____
_____ Immunizations
_____ Prenatal Records
_____ Consultations

I specifically consent to release information relating to: (initial selection)

___ STD ___ HIV/AIDS ___ TB ___ Drug/Alcohol ___ Mental Health

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ Client/Representative Signature

_____ Date

_____ Printed Name

_____ Representative's Relationship to Client

_____ Witness (optional)

_____ Date

Client Name: _____

ID#: _____

DOB: _____

Original: To File **Copy:** To Client **Copy:** To Accompany Disclosure