



## AUTHORIZATION FOR NONROUTINE DISCLOSURE OF PROTECTED HEALTH INFORMATION

### INFORMATION MAY BE DISCLOSED BY:

Person/Facility: The MCGREGOR CLINIC, INC. Phone #: (239) 334 – 9555

Address: 3487 BROADWAY, FORT MYERS, FLORIDA 33901 Fax #: (239) 334 – 2832

### INFORMATION MAY BE DISCLOSED TO:

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Consent to Fax

### INFORMATION TO BE DISCLOSED: (Initial Selection)

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

### 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 redislosed 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