Bonita Community Health Center
3501 Health Center Boulevard
Bonita Springs, Florida 34135
Tel 239-949-1050 Fax 239-949-6132

Authorization to Release Protected Health Information

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize

_____
Provider/Facility Address
_____to disclose the following
Phone Number Fax Number

Information from the health records of: _____DOB:_____
Patient's Full Name
Date of Birth_____ Patient Medical Record #_____

Patient Address_____

Covering the period of healthcare from: (date)_____ to (date)_____

Information to be disclosed:
_____Complete health record _____History & Physical _____Laboratory Tests/Diagnostics
_____Operative Report _____X-Ray Reports _____Other _____

This information is to be disclosed to_____
Name Address
_____ for the purpose of _____
Phone Number Fax Number

The following items must be initialed to be included in the use and/or Disclosure.

1. ____HIV/AIDS related information and/or records HBV,TB or other Communicable diseases
2. ____Mental Health Information and/or Records
3. ____Domestic Violence
4. ____Drug/Alcohol diagnosis, treatment or referral information. (Federal regulations require a description of how Much and what kind of information is to be disclosed) Describe:_____

_____

CONSENT TO MINORS

Minors are permitted to consent to medical care and treatment in the following situations. Thus the parents are not entitled to the minor's medical information without consent of the minor, a subpoena or court order.

1. A minor who is or has been married.
2. An unwed pregnant minor consenting to the performance of medical or surgery care or services relating to her pregnancy.
3. As unwed minor mother consenting to the medical or surgery to the medical or surgical services of their child.
4. A minor seeking voluntary substance abuse impairment services.
5. A minor consenting to the examination and treatment of a sexually transmitted diseases.
6. A minor receiving contraceptive information or services.
7. A minor with a court order removing the disability of nonage
8. Unless a parent objects in writing, any minor who has reached the age of 17 years may give consent to the donation, without compensation therefore, of his/her blood and to the penetration of tissue which is necessary to accomplish such donation.

Copies of records for personal use will be charged at $1.00 per page plus applicable tax and postage. Copies for continuity of care will be sent directly to the physician or healthcare facility at no charge. According to the Privacy Notice, I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire in 90 days. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient/Legal Representative Date

Signature of Witness Date