RESET

Request will not be processed unless form is completed in its entirety.

WATSON CLINIC LLP
Quality Healthcare for Every Generation

Health Information Management • Release of Information Services
P.O. Box 95000 • Lakeland, Fl 33804-5000 • Telephone: 863-904-2652 • Fax: 863-904-2630

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE PRINT

RELEASE MEDICAL RECORDS FROM: *Watson Clinic's Retention Policy is 10 years*	**DISCLOSE INFORMATION TO:**
Physicians/Specialty: _____	Name: _____
_____	_____
_____	Address: _____
_____	_____
_____	Phone: _____ Fax: _____
_____	**Physician Appointment Elsewhere:** _____ (DATE and TIME)

IDENTIFYING INFORMATION:

PATIENT'S FULL NAME _____ PATIENT'S DATE OF BIRTH _____

ADDRESS _____ PATIENT'S PHONE NUMBER _____

CITY/STATE/ZIP _____ PATIENT'S MEDICAL RECORD NUMBER _____

PURPOSE OF DISCLOSURE: ☐ Personal ☐ Continued Care ☐ Other: _____

Please check the following health information items to be released with a beginning date of _____ through _____ .

☐ Office Visits ☐ Pathology Reports ☐ Lab Reports ☐ Immunizations **Radiology:** ☐ Reports ☐ Copy via CD

☐ Other: *(List specific information)* _____

DELIVERY INSTRUCTIONS: *(Select one of the following)*

☐ Mail to Patient ☐ Mail to Company ☐ Fax to Company ☐ Patient Pick-Up

I understand that I may be charged for copies of this information in accordance with Florida Law.

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in **one year** from the date signed below unless otherwise specified _____.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Management Supervisor, Watson Clinic LLP, P.O. Box 95000, Lakeland, Florida 33804-5000.

I understand that Watson Clinic LLP will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

X _____ _____ Date: _____

Signature of Patient or Patient's Representative — Relationship *(if not patient)*

_____ _____

Name of Personal Representative — Description of Authority to Act