

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

PLEASE PRINT

RELEASE MEDICAL RECORDS FROM: <i>Watson Clinic's Retention Policy is 10 years</i> Physicians/Specialty: _____ _____ _____ _____ _____	DISCLOSE INFORMATION TO: Name: _____ Address: _____ _____ Email: _____ Phone: _____ Fax: _____ Physician Appointment Elsewhere: _____ <div style="text-align: right; font-size: small;">(DATE and TIME)</div>
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IDENTIFYING INFORMATION:

_____ PATIENT'S FULL NAME	_____ PATIENT'S DATE OF BIRTH
_____ ADDRESS	_____ PATIENT'S PHONE NUMBER
_____ EMAIL	_____ PATIENT'S MEDICAL RECORD NUMBER

PURPOSE OF DISCLOSURE: *(select one of the following)* Patient's Request Other: _____
 Continued Care

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 Radiology CD
 Other: *(List specific information)* _____

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

Mail to Patient Fax to Company Patient Pick-Up *(Watson Clinic Location)* _____
 Datavant's Patient Portal Watson Clinic MyChart

I understand that I may be charged for copies of this information in accordance with applicable 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, birth control and family planning, communicable diseases, hospice, or genetic test results. By Signing below, I specifically authorize the release of this information.

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, Watson Clinic and its employees, officers, directors, medical staff members, and business associates are not responsible for the privacy and security of the above information once it is disclosed as allowed on the form.

X _____ Date: _____
Signature of Patient or Patient's Representative Relationship *(if not patient)*

Name of Personal Representative Description of Authority to Act