STANKUS FAMILY CARE
Healthcare with heart

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations		
Patient Name:	DOB:	SSN:
Office/Provider Name:	Recipient Name: **Stankus Family Care** **18743 NW 234TH ST.** **High Springs, FL 32643**	
Provider's Fax Number:	**Phone: (386) 454-0721 Fax: (386) 454-0722**	

Expiration Date or Event: This authorization will expire on the following expiration date (or) event

Date: Event: Death

Purpose of Disclosure:

Section B: Description of Information to be Used or Disclosed

Is this a request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

☐ No, then you may check as many items as you need below.

Description:	Date of Service(s):	Description:	Date of Service(s):
☐ All PHI in Medical Records ☐ Progress Notes ☐ Clinical Test(s) ☐ Medication Sheets		☐ Special Test/Therapy ☐ Itemized Bill(s) ☐ HCFA-1500 Claim(s) ☐ Other:_____	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law, such as: alcohol, drug abuse, mental health, AIDs, or HIV testing or treatment.
3. My treatment, payment, enrollment, or eligibility may not be conditioned.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I can request a copy of this form at any time, if needed.

Section C: Is the request of PHI for the purpose of marketing? YES NO

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?

☐ **NO** ☐ **YES** **If YES, describe:**

Section D: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient, Guardian, or Personal Representative:	Date signed:
Printed Name or Patient, Guardian, or Personal Representative:	Relationship to Patient: