GMS Florida West Coast, Inc.
Northwest Family Medical Center
4278 W. Linebaugh Ave, Tampa FL 33624
813-960-3321 Fax 813-264-7532

Patient Authorization to Obtain or Disclose Protected Health Information

Patient Name:	Date of Birth:
Address:	SS# or Account #:

I hereby authorize GMS Florida West Coast, Inc.("GMS") to use, disclose and/or obtain the above-named patient's health information as follows *(check all that apply):*

☐ DISCLOSE the following health information to:	☐ OBTAIN the following health information from:
_____	_____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Description of health information to be disclosed/obtained *(include dates of service, type of service, etc):* _____

_____

This health information is disclosed/obtained for the following purpose *(If Authorization requested by the patient put : "At the request of the individual'):*

By providing this Authorization, I understand as follows:

I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.

I. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:
   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
2. I understand that GMS will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.
3. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by federal or state law.
4. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.
5. I understand that I may revoke this Authorization at any time by notifying GMS in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one year.
6. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.
7. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just *as* the original.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient or Patient's Representative *(if applicable and relationship)*

_____

Witness