Avance Care®

Primary Care for Busy Lifestyles℠

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____
(mm/dd/yyyy)

Phone _____ Email: _____

Due to the Privacy Act please list names of anyone you would like to have access to your medical information. Please understand that without your consent, we will deny any request for information to family members. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize Avance Care, P.A., its staff and providers to disclose my protected health information to the following representative:

Representative Name:_____ Relation to patient: _____
(full name)

Protected health information I, the patient listed above, allow to be disclosed to the above representative or organization includes:

☐ **All information** – clinic notes, treatments, past medical history, lab and test results, and information that may pertain to HIV status, mental health, and substance abuse/dependence.

☐ **Select Information:** _____

This authorization is **valid for one year unless specified**:_____

Please read the following: You have the right to revoke this authorization at anytime by notifying Avance Care, P.A., in writing. The revocation will be effective on the date notified and will not apply to all information that has already been released in response to this authorization. Avance Care, P.A., it's staff or providers may deny access to protected health information to the above representative in certain situations and conditions. If denied access, Avance Care, P.A. will notify the patient in writing the reason for denial if requested.

Patient Signature:_____ **Date:**_____

Office Use Only: Please document the authorization in the system at:
Patient Information -> Additional Info -> Structured -> Disclosure of Medical Information