Michael K. Smith, M.D.

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Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

I authorize Michael K. Smith, M.D., P.A. to disclose/release information to and obtain information from:

Name of organization or person: _____

Address: _____

Phone Number(s): _____ Fax Number: _____

The purpose of the disclosure is:_____

__Entire Record __Consultation Report

__Diagnoses __Summary of Initial Evaluation

__Medication List __Discharge Summary

__Laboratory Results __Other:_____

I understand that AI have the right to cancel/revoke this authorization at any time. I understand that if I wish to cancel/revoke this authorization, I must do so in writing and present my written cancellation/revocation to Michael K. Smith, M.D., P.A. I also understand that the cancellation/revocation will not apply to information which has already been released in response to this authorization, as stated in the Notice of Privacy Practices. Unless otherwise cancelled/revoked, this authorization will NOT expire.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged. I understand that the transfer of the above information may involve written, printed or verbal communication and may occur by phone, fax, email or direct person to person communication.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person or organization receiving the information, as detailed in Notice of Privacy Practices. I understand I may be given a copy of this authorization.

Signature of Patient (or patient's personal representative—describe) _____

Printed Name of Patient or representative_____Date_____
