GESSLER CLINIC, P.A.

635 First Street North
Winter Haven, FL 33881
(863) 294-0670, Ext. 3263

Authorization for Release and Use of Protected Health Information Under HIPAA

Patient's Name: _____ Soc. Sec. #_____

Date of Birth: _____ Telephone: _____

1. The undersigned Patient named above, hereby executes this authorization in compliance with the Health Insurance Portability and Accountability Act, HIPAA 45 CFR 164.104, and requests that the following health care provider (including its agents, employees and associates) release his or her records:

RELEASE RECORDS FROM:

Name: _____

Address: _____

_____

2. The above named health care provider is requested to release the protected health information (PHI) as described below to:

RELEASE RECORDS TO:

Name: _____

Address: _____

_____

RECORDS ARE TO BE: ( ) Picked Up ( ) Mailed

3. The protected health information released herein may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), drug/alcohol records, psychiatric/psychological information/records unless specifically listed below under exclusions:

( ) ALL RECORDS	( ) X-Ray Films / CD	( ) Progress Notes	( ) Operative Reports
( ) ER Records	( ) Discharge Summary	( ) H & P	( ) Lab/Radiology Reports

( ) Other/Specific Date: _____

	Initials		*Initials*
EXCLUSIONS:	_____ Drug/alcohol abuse or treatment		_____ HIV/AIDS testing/treatment
	_____ Psychiatric/psychological records		_____ Sexually transmitted disease

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A. Purpose of Disclosure: ( ) MEDICAL CARE ( ) OTHER: _____

B. This authorization may be revoked at any time by a signed and properly dated written revocation sent to the specific health care provider being provided with the request, but this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

C. I understand that I am under no obligation to sign this document and that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

D. I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations. Gessler Clinic cannot guarantee that the recipient of the information will not re-disclose this information.

E. A photocopy of this authorization shall be considered as effective and valid as the original and this authorization will expire ninety (90) days after the date executed, unless earlier revoked.

_____ _____

Patient's Signature/ Legal Representative Signature (specify relationship) Date