ALAFAYA WOODS FAMILY MEDICAL CENTER, P.A.
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, and treatment, any plans for the future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care or treatment
- Communicate with other health professionals or entities who contribute to your healthcare.
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you.

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTCHARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and health care entities (such as referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment, and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice, text messages, email or with a household family member.
  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member
  [ ] Please check here if you do not want us to leave a message on your mobile voice mail/text messaging.
  [ ] Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.
- To discuss your health or payment information (only the minimum necessary in our judgement" with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information._____
  _____
- You may request a copy of and you have the right to read our "Notice of Patient Privacy Practices" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.
Patient Name (please print): _____

_____ _____ _____
Signature Print name of person signing in other than patient Date

FOR OFFICE USE ONLY: Patient refused to sign this form. Reason: _____ Date: _____