AzureWave Medical Services, LLC

Authorization to Release Protected Health Information (PHI)

Patient Information:
Name: _____
Date of Birth: _____
Phone: _____

I hereby authorize AzureWave Medical Services, LLC to:

■ Release my protected health information TO:
■ Obtain my protected health information FROM:

Name of Individual/Organization: _____
Address: _____
Phone: _____ Fax: _____

Description of Information to be Released (check all that apply):
■ Complete Medical Record
■ Office Notes
■ Laboratory Results
■ Imaging Reports
■ Billing Records
■ Medication Records
■ Other: _____

Purpose of Disclosure (check one):
■ Continuity of Care
■ Insurance/Payment
■ Legal
■ Personal Use
■ Other: _____

Expiration:
This authorization will expire one (1) year from the date signed unless otherwise specified below:
Expiration Date or Event: _____

Florida & Federal Sensitive Information Disclosure:
This authorization specifically includes permission to disclose information related to:
• Mental health records (F.S. §456.057)
• Substance use disorder treatment records protected under 42 CFR Part 2
• HIV/AIDS and sexually transmitted disease information (F.S. §381.004)
• Genetic testing information
• Sexually transmitted infections
• Psychotherapy notes (if applicable)

I understand that substance use disorder records protected under 42 CFR Part 2 may not be redisclosed
by the recipient without my written consent unless otherwise permitted by federal law.

Exclusions (if any information is NOT to be disclosed):

_____

Revocation:
I understand that I may revoke this authorization at any time by submitting a written revocation to AzureWave Medical Services, LLC, except to the extent that action has already been taken in reliance upon it.

Redisclosure Warning:
Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under HIPAA.

Voluntary Authorization:
I understand that signing this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon signing this form unless permitted by law.

Verbal Authorization Documentation (Office Use Only):
If authorization is provided verbally, the following must be completed:
Date of Verbal Authorization: _____
Name of Staff Witness: _____
Description of Information Released: _____
Reason Verbal Authorization Accepted: _____
Provider Signature (if required): _____

By signing below, I authorize the use or disclosure of my protected health information as described above.

Signature of Patient or Legal Representative:
_____

Printed Name of Representative (if applicable):
_____

Relationship to Patient: _____

Date: _____