

**Authorization for Release of Protected Health Information to
Family Members/Legal Guardian**

Patient Name: _____ DOB: _____

1. Authorization

I hereby authorize Central Florida Rheumatology Consultants and its representatives to disclose my protected health information (PHI) to the following individual(s):

Name(s) of Family Member(s):

2. Type of Information

(Initial next to each type of information you authorize to be released)

____ General Medical Information (diagnosis/treatment plans)

____ Lab reports

____ Billing and Insurance Information

____ Appointments and Scheduling

____ Leave voice mails for family members with protected health information if requested.

____ Other: _____

3. Expiration of Authorization

This authorization is valid:

Until revoked in writing

Until the following date or event: _____

4. Right to Revoke

I understand that I have the right to revoke this authorization at any time by submitting a written request to Central Florida Rheumatology Consultants. The revocation will not apply to information already released in reliance on this authorization.

5. Acknowledgement and Signature

I understand that:

- I am not required to sign this authorization in order to receive treatment.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- I have the right to inspect or copy the information to be disclosed.

Signature of Patient or Legal Representative: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.