Keith Van Dyke, M.D.
Marcella Bujnovsky, M.D.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____, hereby authorize_____ to release copies of the medical records of:_____
DOB:_____SS#_____

Send Information to (name of person, organization, or agency with full address)

Name:_____
Attention:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

Purpose of release (*For Example: Continued care, personal, etc):*_____

The items that may be released shall include:
Complete Records:_____ Last 2 years:_____ Other:_____

Please initial the items that may be released:
HIV Results:_____ STD Testing:_____ Drug and/or Alcohol Abuse:_____ Mental Health:_____

As required by state and federal law, Van Dyke GYN may not use or disclose your health information, except as provided in our notice of privacy practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Van Dyke GYN cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Van Dyke GYN 9161 Narcoossee Road Suite B209, Orlando, FL 32827. I further understand that any such revocation does not apply to information already released in response to this authorization.

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

I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release Van Dyke GYN and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I may be charged a fee; this fee is waived for copies provided to a health care provider for continuing medical care. I understand that this fee is with the limits allowable by Florida Law.

I hereby authorize Van Dyke GYN to release health information as described above.

Patient's Signature:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____

Relationship to Patient:_____

Witness:_____Date:_____