LifeForce Healthcare, LLC

Phone: 352-873-3800
Fax: 352-873-4800

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____

Date of birth: ______________ Social Security number: ____________________

Requestor: LIFEFORCE HEALTHCARE, LLC
Provider: _______________________________

Address: PO BOX 773176, OCALA, FL 34477

Fax Number: 352-873-4800

PHI Sender Name: ____
Address/City/State/Zip: ____
____
Phone Number: ______________________ Fax Number: _____________________

This authorization will expire on the following: (6 months from date form is completed)
Date: ________________

Description of what shall be disclosed	Yes
All PHI in record	
History and Physical	
Consult Report	
Progress Notes	
Orders	
Laboratory	
Imaging/Radiology	
Medication Record	
Special Test/Therapy	
Other:	

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ___________ (Initial)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.

Signatures
I have read the above and authorize the disclosure of the protected health information as stated.
Signature of Patient/Guardian/Patient Representative:
Date: ________________
Print Name of Patient/Representative: ____
Signature: ____
Relationship to Patient: ____