Barbara A. Lubin, MD LLC 1124 Jenks Ave, Panama City, FL 32401
Phone (850)785-8246 **Fax** (850)785-8249 **www.lubinMD.com**

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:

Full Name: _____ Date of Birth: _____

Other Name(s) Used: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Release my medical records to Barbara A. Lubin, MD LLC

Address: 1124 Jenks Ave, Panama City, FL 32401

Phone: (850) 785-8246 Fax: (850)785-8249 Email: practice@lubinmd.com

Release my medical records from (PROVIDER NAME/PHONE# AND FAX#)

_____

_____

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ 2 Years, including patient histories, office notes, test results, radiology studies, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)

□ Treatment/Continuing Medical Care

□ Personal Use

□ Billing or Claims

□ Insurance

□ Legal Purposes

□ Other (Specify): _____

PATIENTS RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Barbara A. Lubin, MD office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in **one year** from the date signed.

I understand that authorizing the disclosure of this health information voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized disclosure and the information may not be protected by federal confidentially rules.

_____ _____

Signature of Patient or Legal Representative Date