COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

☐ Johnnie Ruth Clark Health Center*1344 22nd Street South*St. Petersburg, FL 33712* fax: 727-824-8150 (adult) 727-823-7429 (peds)
☐ Johnnie Ruth Clark Health Center*1344 22nd Street South*St. Petersburg, FL 33712* fax: 727-824-8137 (obgyn)
☐ CHCP at Bayfront*701 6th Street South*St. Petersburg, FL 33701*727.893.6443* Fax:727.209.5619
☐ CHCP at MLK*612 MLK Jr. St. North*St. Pete, FL 33705*727.824.8181*Fax: 727.209.0309
☐ CHCP at Pinellas Park*7550 43rd Street North*Pinellas Park, FL 33781*727-544-2284*fax: 727-541-7984
☐ CHCP at Suncoast*5523 Roosevelt Blvd*Clearwater, FL 33760*727.824.8181*fax: 727-286-6224
☐ CHCP at Clearwater*707 Druid Road East*Clearwater, FL 33756*727-461-1439*fax: 727-443-7230 (adult)*fax: 727-461-1692 (peds)
☐ CHCP at Largo*12420 130th Avenue North*Largo, FL 33774*727-587-7729*fax: 727-587-7739
☐ CHCP at Lealman*4950 34th Street North*St. Petersburg, FL 33714* Fax: 727-202-7908
☐ CHCP at Dunedin*1721 Main Street*Dunedin, FL 34698*727-824-8181*fax:727.736.1735
☐ CHCP at Tarpon Springs*247 South Huey Avenue*Tarpon Springs, FL 34689*727.944.3828*fax: 727.939.4679
☐ CHCP at Oldsmar*3860 Tampa Road, Suite C*Oldsmar, FL 34677*727.824.8181*fax 813.543.0315

Authorization for Release of Medical Information

Patient Name: _____ Date: _____

SS#: _____ Date of Birth: _____ Chart #: _____

I authorize *Community Health Centers of Pinellas, Inc.* to ☐ release ☐ collect my protected health information as described below.

Purpose or Need for Disclosure	**Type of Information to be disclosed**
☐ Further Medical Care ☐ Application for Insurance ☐ Obtain payment for claims ☐ Patient's request (personal use) ☐ SS Disability ☐ Legal Investigation/Action ☐ Other _____	☐ Entire record ☐ Radiology/Imaging ☐ Laboratory ☐ MD Orders ☐ MD Progress Notes ☐ History & Physical ☐ Face Sheet/Insurance info. ☐ Other _____

Records to be released: ☐ **To the address below** ☐ **From the office listed below**

_____
Name of person or organization

_____
Street Address

_____
City/State/Zip Phone Number

This authorization shall be valid for **ONE YEAR** unless otherwise stated or revoked through written notice to Community Health Centers of Pinellas, Inc.
Alternate date or event if not one year _____

_____ **I acknowledge, and hereby consent to such, that the released/requested information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information.**
Patient Initials

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Inspect or Copy the Health Information to Be Used or Disclosed-I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorized form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Clinic marked above. **Right to Receive Copy of This Authorization-**I understand that if I agree to sign this authorization, I have a right to receive a signed copy of the form. **Right to Refuse to Sign This Authorization-**I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above, who I am authorizing to use and/or disclose my information may not condition treatment or payment on my decision to sign this authorization. **Right to Revoke This Authorization-**I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact the clinic listed above. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named-to disclose such information as herein contained. I understand that this authorization may be withdrawn, by written request from me, at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged from any liability, and the undersigned will hold the facility harmless, for complying with this "Release of Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization. I understand federal and state laws permit a fee to be charged for copying of patient records, and it is up to the discretion of the above facility to collect said fee(s).

_____ _____
Signature of Patient/Parent/Conservator/Guardian Date

_____ _____ _____
Relationship to Patient/Authority to act for patient ID Presented Verified By

Notice to the Recipient: The recipient of the enclosed information is not authorized to use this patient's Medical Records information for any purpose other than for that stated above, or to disclose any information to any other person/facility without specific written authorization from the patient to do so.

A copy of this completed, signed and dated form must be given to the Individual or other Authorized Representative upon request.