

HIPAA PRIVACY RELEASE

PERMISSION TO SHARE YOUR PRIVATE HEALTH INFORMATION

I understand my medical records are protected by federal law and that information can only be released as per the Health Information Privacy and Portability Act.

Patient Name

I DO NOT AUTHORIZE TO SHARE MY PRIVATE HEALTH INFORMATION

If checked, please sign the form below

I AUTHORIZE TREASURE COAST PRIMARY CARE TO SHARE MY PRIVATE HEALTH INFORMATION

If checked, please provide the information below

SHARE MY PRIVATE HEALTH INFORMATION WITH THE FOLLOWING INDIVIDUAL(S):

Please list Name & Phone Numbers

NOTICE OF VOICEMAIL AND MESSAGES

Voice messages may be left on the phone number(s) provided:

YES

NO

Emailed COVID-19 results may be sent without HIPAA Encryption requirements:

YES

NO

* RESTRICTIONS ON INFORMATION TO BE DISCLOSED

I request the following restrictions on the information disclosed:

Mental Health Records

Do not disclose these records

Communicable Diseases, including HIV/AIDS, Alcohol/Drugs, Genetics

Do not disclose these records

Other _____

Do not disclose these specified records

Patient Signature

Date

I understand I can revoke this authorization at any time by submitting a request in writing to **Treasure Coast Primary Care**.