STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used and/or Disclosed
The information covered by this authorization includes:
Please initial if HIV and Or Psychiatric records should be disclosed.

_____	Complete Medical Records	_____	Medication List
_____	Problem List	_____	X-Ray Reports
_____	All Laboratory Results	_____	Office Visits
_____	**HIV/AIDS ( ) initial**		
_____	**Psychiatric/Psychological Records ( ) initial**		
_____	Other Results/Reports	_____	
_____		_____	

Persons Authorized to Disclose information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Person to Whom Information May Be Disclosed

Midtown Medical Center
6919 North Dale Mabry Highway, Suite 300
Tampa, Fl 33614
Telephone # 813-935-3221 Fax # 813-933-8149

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patients representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **Midtown Medical Center**. You should contact the **Medical Records Dept** to terminate authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Print Name of Patient Patient Date of Birth

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient