Prime MD of Naples
COMPREHENSIVE PRIMARY CARE

Authorization for the Use and Disclosure of Protected Health Information (PHI)

The form is used to authorize Prime MD of Naples to disclose protected health information to the person (s) entity (ities) designated below. Please complete the following information. All sections must be completed, or the form will be considered incomplete and returned to you.

SECTION 1 – DEMOGRAPHIC INFORMATION:

Patient Name : ____ DOB: ___________________

Phone Number: __________________________ Alternative Number: _____________________

SECTION 2 – PURPOSE OF THE AUTHORIZATION:

Please note that by signing this form, you will authorize Prime MD of Naples to disclose your protected health information for the following purposes. Describe the purpose of the authorization.

☐ Emergency care if incapacitated

☐ Ongoing care/treatment

☐ Other

SECTION 3 – PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

Please indicate the specified protected health information you authorize us to disclose for the purpose stated above:

☐ Any/all concerning myself

☐ Related to a specific problem/issue (must list)

☐ Related to a particular service date:

SECTION 4 – PERSON AUTHORIZED TO RECEIVE:

Please indicate the person(s) / entity (ities) and date to which you are authorizing Prime MD of Naples to disclosure the protected health information described above.

Name: ____ DOB: _____________________

Relationship to Patient: _____________________________ Contact Number: ____________

I authorize Prime MD of Naples to leave message on answering machine/voicemail: YES or NO

Name: ____ DOB: _____________________

Relationship to Patient: _____________________________ Contact Number: ____________

I authorize Prime MD of Naples to leave message on answering machine/voicemail: YES or NO

Name: ____ DOB: _____________________

Relationship to Patient: _____________________________ Contact Number: ____________

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SECTION 5 – EXPIRATION

This authorization is in effect unless I revoke it in writing and/or I am no longer a patient with Prime MD of Naples.

SECTION 6 – STATEMENT OF UNDERSTANDING:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits. I understand that Prime MD of Naples is released from all legal responsibility and/or liability that may arise from the release of such records. I understand that, if the person or entity I authorize to receive PHI described in this form is not a health plan, covered health care provider or health care clearing house subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws.

I further understand by signing this authorization, I consent to the electronic transmissions of any prescription(s) to the pharmacy(ies) I provide. By signing this consent form you also agree that Prime MD of Naples can request and use your prescription medication history from other healthcare provides and/or third-party pharmacy benefit payor for treatment purposes.

The undersigned represents that he/she has read and understands the information contained here, and that they agree to the terms and conditions of this authorization.

Patient/Authorized Signature: ______________________________________ Date/Time: __________

Printed Patient Name (if not patient) ________________________________ Date/Time: _________

Witness: ____ Date/Time: _________

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