AdventHealth
Medical Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PLEASE PRINT

Today's Date:________________________________Patient's SSN: ______________________________

Patient Name:________________________________Date of Birth: ______________________________

Address:____

Phone Number: H-______________________W-______________________C-______________________

Describe the information you approve disclosure of:

☐ All aspects of my healthcare as allowed to me under applicable law.

☐ Other:____

To whom you approve disclosure:

Name:____Relationship:________________________________

Phone #:_________________________Address:____

City:____________________________State:_______________Zip Code: ___________________________

Name:____Relationship:________________________________

Phone #:_________________________Address:____

City:____________________________State:_______________Zip Code: ___________________________

Name:____Relationship:________________________________

Phone #:_________________________Address:____

City:____________________________State:_______________Zip Code: ___________________________

- I understand that I still have a right to access my PHI as allowed under applicable law.
- I understand that I may receive an accounting of disclosures as explained in AdventHealth Medical Group's Notice of Patient Privacy Practices.
- I understand that my PHI may be disclosed for public policy purposes as stated in the AdventHealth Medical Group's Notice of Patient Privacy Practices.
- I understand that AdventHealth Medical Group may terminate its agreement to use or disclose any of my PHI at any time but only after I have received notice of such termination.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written authorization to the Health Management Department. I understand that my revocation will not apply to information already released in response to this authorization.

Signature of Patient or legal representative: ____

Printed name of legal representative:______________________Relationship to Patient: _______________

Address and phone number of legal representative: ____

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Practice Location: AdventHealth Medical Group