



Bonita Community Health Center
3501 Health Center Boulevard
Bonita Springs, Florida 34135
Tel 239-949-1050 Fax 239-949-6132

Authorization to Release Protected Health Information

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize

Provider/Facility Address

to disclose the following

Phone Number Fax Number

information from the health records of: Patient's Full Name

Date of Birth Patient Medical Record #

Patient Address

Covering the period of healthcare from: (date) to (date)

Information to be disclosed:

- Complete health record Progress Notes Consultation Report
History & Physical Laboratory Tests EKGs
Operative Report X-Ray Reports Other

This information is to be disclosed to Name Address

for the purpose of Phone Number Fax Number

Copies of records for personal use will be charged at \$1.00 per page. Copies for continuity of care will be sent directly to the physician or healthcare facility at no charge. According to the Privacy Notice, I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire in 90 days. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient/Legal Representative Date

Signature of Witness Date