Trinity Family Medical Center, P.A.

Dr. Stephen E. Young
1707 Mayo Drive
Tavares, FL 32778

Patient Authorization for Use and Disclosure of Protected Health Information

Patients Name:_____

By signing, I authorize **Trinity Family Medical Center** to use and/or disclose certain protected health information (PHI) about me to the following organizations and/or individuals: (primary care physicians, specialists, hospitals, family members, friends, etc.)

Name:	**Phone Number:**	**Relationship to patient:**
_____	(_____)_____	_____
_____	(_____)_____	_____
_____	(_____)_____	_____
_____	(_____)_____	_____

☐ **Yes/no, you may leave a message on my answering machine or cell phone confirming appointments or other information.**

I, _____, have had full opportunity to read and consider the contents of this authorization and I confirm that the contents are consistent with my direction to you. I acknowledge that I am aware of **Trinity Family Medical Center, P.A. Notice of Privacy Practices** and have had full opportunity to read and consider the contents of the practices. I understand when my information is used or disclosed pursuant to this authorization; it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, **(if applicable)**

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT