



321.674.2114 | f.321.674.2118

### Authorization for Release of Protected Health Information

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Patient Acct. #: \_\_\_\_\_

I hereby authorize Zipper Urogynecology Associates to disclose Protected Health Information of the above named patient to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Information authorized to release:  Medical Records  
 Billing Records

Information authorized to release for services rendered during the period from \_\_\_\_\_ to \_\_\_\_\_, to include any Federal and State protected information under Florida Statute 394.459(9) psychiatric information, Florida Statute 397.053 and Florida Statute 396.112, Drug and/or Alcohol Abuse information and Florida Statute 381.608(2) Human Immunodeficiency Virus test results (AIDS and related conditions).

I understand that authorizing the disclosure of this protected health information is voluntary. I understand that authorizing the disclosure of this protected health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of protected health information, I may contact Zipper Urogynecology Associates Office Manager.

I understand and direct that this authorization remains in effect for six (6) months or until I revoke it in writing. I hereby release Zipper Urogynecology Associates and its employees from any and all liability that may arise from the release of this protected health information as I have directed.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness