HOPKINS CLINIC
6231 66TH Street North
Pinellas Park, FL 33781
Tel: 727 544 – 3330 Fax: 727 544 - 3221

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ **ID Number:** _____

Persons/organizations providing the information:	**Person/organizations receiving the information:**
_____	Hopkins Clinic
_____	6231 66TH Street North
_____	Pinellas Park, FL 33781
_____	Tel: 727 544 – 3330 Fax: 727 544 – 3221

Specific description of information (including date(s)):

___X-ray films ___X-ray Reports ___MRI Reports ___CT Reports ___Narrative Reports

___Nerve Conduction / EMG Reports ___Physical Therapy Progress Notes

___Emergency Room Records ___All Medical Records

Other _____

Dates: From _____ To _____

1. The provider must complete the following statement:
   a. will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No **XXX**

2. The patient must read and initial the following statement:
   a. I understand that I get a copy of this form after I sign it. Pt. initials:_____

The patient or the patient's representative must read and initial the following statements:
1. I understand that this authorization will expire on __ __/__ __/__ __ __ __ (DD/MM/YYYY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: _____

_____ _____
Signature of patient or patient's representative Date
(*Form MUST be completed before signing)*

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

THIS RECORDS RELEASE FORM IS HIPAA COMPLIANT

HIPPA form (Rev. 090106)