Dr Bob's Compassion Clinic

6088 W Nordling Loop, Crystal River, Fl 34429 (352)601-4200

Authorization for Release of Protected Health Information

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, this practice may not use or disclose your health information without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section.

Patient Name:_____

Patient Phone Number: _____. Date Of Birth _____

Last 4 Social Security #: XXX-XX-_____

AUTHORIZATION SECTION:

I, hereby authorize the use and disclosure of the following health information that pertain to me: ***The clinic notes from the last 2 visits will be sufficient.***

___ Medical Records ___ Mental/Behavioral Records ___ Office Notes. ___Other (specify)

This signed Authorization will expire in one (1) year unless an earlier date is indicated. This Authorization will no longer be valid after _____. I understand that I may revoke this authorization at any time.lease

FAX TO: Doctors Name:_____Phone # _____ FAX _____

_____ _____

Signature of Patient/Legal Guardian **Date**

Please Fax or Mail records to: Dr. Bob's Compassion Clinic
6088 W Nordling Loop
Crystal River, Fl 34429
Fax: (352) 414-4231

Office notes: Faxed: Received