SUBLETTE LAW OFFICES

A FLORIDA PROFESSIONAL ASSOCIATION
SUITE 1220
250 NORTH ORANGE AVENUE
ORLANDO, FLORIDA 32801

WILLIAM E. SUBLETTE, ATTY. AT LAW
AMY OGLE, PARALEGAL
KIMBERLY JANUZZI, PARALEGAL
SABRINA GIMENEZ, LEGAL ASSISTANT

PERSONAL INJURY
WRONGFUL DEATH
PROFESSIONAL NEGLIGENCE

TELEPHONE: (407) 426-8551
TELECOPIER: (407) 426-7789
BILL@SUBLETTELAW.COM
AMY@SUBLETTELAW.COM
KIMBERLY@SUBLETTELAW.COM
SABRINA@SUBLETTELAW.COM
WWW.SUBLETTELAWOFFICES.COM

Patient Authorization for the Use and Release of Protected Health Information

Patient Name: _____ Medical Record Number: _____
Date of Birth: _____ Account Number: _____
SSN: _____ Telephone Number: _____

1. By signing this authorization, I authorize the use or release of certain protected health information (PHI) about me to my attorney, William E. Sublette, Esquire, Sublette Law Offices, 250 N. Orange Avenue, Suite 1220, Orlando, Florida 32801, for the purpose of pursuing my legal rights.

2. The following individual or organization is authorized to release information: _____
Address: _____
_____
_____

3. The type and amount of information to be used or released is as follows:

☐	Entire Record	☐ all dates	*or*	☐ from _____	to	_____
☐	Billing Information	☐ all dates	*or*	☐ from _____	to	_____
☐	History & Physical	☐ all dates	*or*	☐ from _____	to	_____
☐	Office Visit Notes & Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Consultations	☐ all dates	*or*	☐ from _____	to	_____
☐	Rehabilitation & Therapy Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Laboratory Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Radiology Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Psychiatric and Psychological Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Hospital Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Emergency Department Records	☐ all dates	*or*	☐ from _____	to	_____
☐	Operative Reports	☐ all dates	*or*	☐ from _____	to	_____
☐	Discharge Summaries	☐ all dates	*or*	☐ from _____	to	_____
☐	Other: _____	☐ all dates	*or*	☐ from _____	to	_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the records custodian for the individual or organization authorized to release information listed above. I understand my revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date , event or condition, this authorization will expire sixty (60) days from the date of my signature.

6. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or released, as provided in 45 C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996. If I have questions about the release of my health information, I can contact the records custodian for the individual or organization authorized to release information listed above.

_____ *or* _____
Signature of Patient — Legal Guardian and Relationship to Patient

_____ _____
Date — Date

_____ _____
Notary Signature and Stamp — Notary Signature and Stamp