COMPREHENSIVE
FAMILY HEALTH

721 S COLORADO AVE.
STUART, FL 34994
T: (772) 888-2545 | F: (772) 888-2742

7805 NW BEACON SQ BLVD #103
BOCA RATON, FL 33487
T: (561) 318-4757 | F: (561) 314-3541

5700 STIRLING RD. #100
HOLLYWOOD, FL 33021
T: (954) 357-0889 | F: (954) 329-0004

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB:_____Account Number:_____

Ph Number: _____

Address: _____

I Authorize: _____

To release copies of my medical records to the following providers: Dr. Paul Gambino, Sarah Hartford APRN, Dan Miller APRN, Bradley Rhatigan APRN and Thomas Rawson PA-C.I authorize release of information in regards to the following portions of my medical record:

___Mental Health ___Test Results ____HIV/AIFS

___Substance Abuse ____Communicable Disease ____All

Only the Following listed below:

_____

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated and it may be used only for the purpose listed on this form. I understand now that my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to this office.

Patient Signature (or legal representative)

_____

Relationship to Patient:_____ Date: _____

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