Sun Lake Medical Associates

18964 N Dale Mabry Hwy

Lutz, FL 33548

Tel: 813.948.2107 Fax: 813.948.2790

Release of Patient Records Authorization

I Hereby Authorize _____ (name of practice) to release a copy of my patient records or x-rays containing information protected health information to Sun Lake Medical Assoc. This authorization is given pursuant to Florida Statue and HIPPA regulations. I understand that Florida Statue 456.057 (10) makes clear any third party to whom records are disclose is prohibited from further disclosing any information in medical record without the expressed written consent of the patient or the patient's legal representatives.

_____ _____ _

_____

Patient or Patients representative's signature Pt's Date of Birth Date signed

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations and prescription pick up) with ( ) spouse ( ) Children ( ) other _____

Please list the family members or significant others, if any, whom we may inform about your medical conditions and/or case of emergency:

Name_____ Relationship_____ Ph ( ) _____

Name _____ Relationship _____Ph ( ) _____

Name _____ Relationship _____ Ph ( ) _____

Messages may be left on my answering machine regarding my health and appointments made Yes / No

ACKNOWLEDGEMNET OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY OF Notice of Privacy Practices and that I have read them or declined the opportunity to read them understand the Notice of Privacy