Embracing Life Wellness Center

Melissa Fickey, M.D.

Sarah Cash, A.R.N.P. • Heather Hughes A.R.N.P.

6332 US HWY 301 S
RIVERVIEW, FL 33578

PH: (813)- 662-5919
FX: (813)- 671-8374

AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____ Patient Name:_____ DOB:_____/_____/_____

This authorization will allow Dr. Fickey to exchange general medical as well as psychiatric/ alcohol/ drug abuse/ HIV/ and or AIDS information from my health record in accordance with Florida Statutes 394, 459, 90.503, 394.4615, 397.501 and Federal Regulations (42 CFR Part 2) with:

INSURANCE COMPANY NAME ONLY:

(Name of Agency/ Organization/ Professional or Individual)

Located on the Back of the Card

Address Information

Located on the Back of the Card

Telephone Number/ Fax Number

I hereby authorize the use or disclosure of my individually identifiable health/ psychiatric/ mental health information as described below. I understand that the information I authorize any person or entity to receive or collect about me may be re-disclosed and no longer protected by federal privacy regulations. I understand the office of Melissa Fickey, M.D. cannot guarantee the privacy of my records once they have been released to an outside party and shall be held harmless from any liability or negligence from the re-disclosure or release of my records.

PLEASE CHECK ALL THE APPLY BELOW

___Physician Discharge Summary	___Psychological Evaluation	___Medical History
___History/ Physical Examination	___Psychiatric Evaluation	___Lab Results
___Consultation	___Progress Notes	___Diagnosis
___Recommendation for Treatment & Care	___Treatment Plans	___Verbal Communications
___Psychiatric Discharge Summary	_X_Billing Records	_X_Insurance Coverage Info
	_____ENTIRE FILE	

Other Information:_____

The purpose for the release and disclosure of this protected health information if for:

___Continuation of Care ___Coordination of Care/Treatment ___Other:_____

A general medical authorization or subpoena duces tecum without a specific authorization provided to release psychiatric/ alcohol/ drug abuse/ HIV and or AIDS information must have this waiver from the patient or his/her legally authorized representative. A copy of this authorization shall be considered as void as an original signed copy. I understand that I have a right to refuse this authorization. If I approve, I further understand that Melissa Fickey, M.D. is released from all legal liability arising from the release of the information requested. Treatment will not be conditioned on the provision of a signed authorization except as permitted by law.

Prohibition on Redisclosure:

This information has been disclosed to you from the records whose confidentiality is protected by Federal law. Any further re-disclosure is strictly prohibited. These records may be protected by Federal Regulation (42CFR Part2). This consent is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance upon it. This authorization will remain valid until written revocation of the authorization id made by the patient or patient's guardian. No authorization shall remain longer than 1 year from the date of its execution.

_____ _____

Patient Signature (If patient is over the age of 18) Date

_____ _____

Legally Authorized Representative's Signature Date

_____ _____

Witness Signature Date