KENNETH H. FARRELL, M.D.
EAR, NOSE AND THROAT

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization for: Copies of Medical Record ☐ Paper ☐ Electronic ☐ Other
☐ Inspect or Review Medical Records

PATIENT INFORMATION		
Patient Name	Date of Birth	Patient ID / MRN
Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone

RELEASE TO / REQUEST FROM	
I AUTHORIZE KENNETH H. FARRELL M.D., P.A. TO RELEASE / REQUEST MEDICAL RECORDS	**PURPOSE**
☐ Release Protected Health Information To: ☐ Request Protected Health Information From:	☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other _____
Person / Organization's Name:	
Address	City, State, Zip
Telephone	Fax

INFORMATION TO RELEASE	
Dates and Type of information to disclose:	MEDICAL RECORD FEES
☐ 2 Years prior from the date last seen ☐ Dates: Other _____ ☐ Specific Information Requested (please list request below): _____	The fee for reproducing medical records is as follows (Florida Rule 64B8-10.003): $1.00 per page for the first 25 pages, 25¢ per page for each additional page.

RESTRICTIONS: Only medical records originated through KENNETH H. FARRELL M.D., P.A. will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand 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.

NOTICE OF RIGHTS

I understand I may 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 KENNETH H. FARRELL M.D., P.A., 6405 N. Federal Highway Suite 104, Fort Lauderdale, FL 33308. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **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 1 year from the date signed.**

I understand that authorizing the disclosure 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 that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

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