THE McGREGOR CLINIC

" . . . giving voice to patient choice."

Client Name **DOB** **SSN**

AUTHORIZATION TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. The authorizations designated on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of all parts of this authorization upon your request.

Section 1 – Authorization for Release of Medical Information
I, _____, do hereby authorize _____ to release to _____ the following for the purpose of disease management and continuing care, or for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Information to be disclosed (Initial Sections):
_____ General medical records created at _____
_____ The following information from the medical record _____
_____ Records obtained from the following providers _____
_____ STD Records
_____ Psychiatric/psychological information/records
_____ TB Records
_____ HIV/AIDS records
_____ Drug/alcohol treatment records
_____ Consent to fax/mail

Section 2 - Medicare Patient Certification, Authorization to Release and Payment Request (only applies to Medicare Clients)
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries / carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above agency and authorize it to submit a claim to Medicare for payment.

Section 3 – Consent to Share Information
As Client/Representative signed below, I hereby authorize the McGregor Clinic, Inc., and any practitioner examining or treating me to share information with _____, in order to maintain continuity of care. Information may include psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, adult or child abuse information including any information received from other healthcare providers concerning diagnosis and treatment.

Section 4 – Assignment of Benefits (only applies to Third Party Payers)
As Client/Representative signed below, I, assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

Redisclosure: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Revocation: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. 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, Medicaid and Medicare.

Client/Representative Signature **Date**

Representative's Relationship to Client **Witness (Optional)**

3487 Broadway Avenue • Fort Myers, FL 33901
Phone: (239) 334-9555 • Secure Fax(es): Medical (239) 334-2832 / Case Mgt (239) 334-2439