FLORIDA CANCER AFFILIATES

☐ 433 SW 10th Street • Ocala, FL 34471
Phone (352) 732-4032 • Fax (352) 732-4191

☐ 13940 US Hwy 441 N • Lady Lake, FL 32159
Phone (352) 259-8940 • Fax (352) 430-1073

☐ 9401 SW State Road 200, Suite #702, Ocala, FL 34481
Phone (352) 237-7170 • Fax (352) 237-8808

HIPAA Release Form

Name: _____ Date of Birth: _____/____/_____

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to notify or assist in the notification of a family member or friend who may be involved in your care.

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

☐ Spouse_____

☐ Child(ren)_____

☐ Other_____

☐ Information is not to be released to anyone.

This HIPAA Release will remain in effect until terminated by me in writing.

When leaving a messages:

Please call ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day of week)_____

between (time) _____ and _____.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____