

3611 Little Road • Trinity, FL 34655  
Phone (727) 372-9159 • Fax (727) 376-8703

13904 Lakeshore Blvd., Ste. 410 • Hudson, FL 34667  
Phone (727) 862-5489 • Fax (727) 862-0397

14535 Cortez Blvd. • Brooksville, FL 34613  
Phone (352)596-3622 • Fax (352) 596-0901

11373 Cortez Blvd., Ste. 200 • Brooksville, FL 34613  
Phone (352) 597-4998 • Fax (352) 596-6051

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: \_\_\_\_/\_\_\_\_/\_\_\_\_