# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Pat T. Tidwell, M.D., P.A.**
**4554 East Hwy 20, Suite 100, Niceville, FL 32578**
**OFFICE 850-678-6735 FAX 888-491-1417**

| Patient Legal Name | Birth Date | Social Security Number |
|---|---|---|
| Address | | Phone number |
| City | State | Zip Code |

I hereby authorize______________________________________________
Facility or Covered Entity
To disclose medical record information and/or protected health information of the patient listed above to:

PAT T. TIDWELL, M.D., P.A.
______________________________________________
Name/Title

4554 HWY 20 EAST SUITE 100, NICEVILLE, FL 32578
______________________________________________
Address/City/State/Zip

Purpose: FOR CONTINUING MEDICAL CARE

For Treatment date:______________________________________________

| Type of Access Requested: Personal Access: | | Selected Portions of PHI: | |
|---|---|---|---|
| ___Copies of the Record | ___Emergency Room | ___Lab | ___Progress Notes |
| ___Inspection of the record | ___H & P | ___Imaging/Radiology | ___Entire Record |
| | ___Consult Report | ___Cardiac Studies | ___Other: ___________ |
| | ___Operative Report | ___Face Sheet | ___________ |
| | ___Rehab Services | ___Medication Record | |

______ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.
Initials

Expiration: This authorization shall expire upon this expiration Date or Event:
UNTIL REVOKED IN WRITING

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient an no longer protected.

Fees/charges will comply with all laws and regulations applicable to release of information.

I have read the above and authorize the disclosure of the protected health information as stated.

| ___________ | ______________________________ | ______________ |
|---|---|---|
| Date | Signature of Patient/Parent/Patient Representative | Relationship to Patient |

______________________________________________
Address and Phone Number of Requestor (if different from patient information)