Preventive Cardiology & Internal Medicine Associates,P.L.
3606 Maclay Blvd. Suite 104
Tallahassee, FL. 32312

VERBAL COMMUNICATION AUTHORIZATION

I, __________________________, DOB ___________________authorize PCAIMA to verbally disclose protected health information contained in my medical and billing records to the individual(s) indicated below. I understand that the purpose of this disclosure is to facilitate communication regarding my medical care. I further understand that this does not authorize release of medical record copies, which requires a separate written authorization by me.

I, __________________________, DOB ___________________ specifically authorize the release of any and all medical information, including that related to mental health, alcohol and/or drug abuse treatment, and HIV (AIDS) testing, treatment or diagnosis.

Initials _______________________Date _____________________

Special instructions or restrictions on disclosure:

You may ____or may not ____ leave messages on my home ____, work ____, cell ___, voicemail____, other ____.

The information indicated above may be released to:
Name: _____________________________
Relationship: ________________________
Number: ___________________________

I understand that I have the right to revoke this authorization, except to the extent that PCAIMA has already taken action based on it. I also understand that when my health information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of the information identifies on this authorization is voluntary and I need not sign this form to ensure health care treatment.

Signature of Patient/Patient's Representative: ____________________ Witness: ____________________________
Relationship to Patient: _______________________________________ Date Witnessed: ______________________
Date signed: ____

REVOCATION OF AUTHORIZATION: I hereby revoke the previous authorization allowing disclosure of my protected health information to the above named individual.

Signature of Patient/Patient's Representative: ____________________________ Date: _______________________