MCC Medical, LLC
Phone: 407-751-5005
Fax: 407-288-8607

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Print Name of Patient: _____

Date of Birth: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information:

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: MOST RECENT VISIT SUMMARY INCLUDING DIAGNOSIS

The above party may disclose this health information to the following recipient:

Name: MCC Medical, LLC
Phone: (407)751-5005
Address: 114 West Underwood St. Suite 2
Fax: (407)288-8607
City, State, Zip Code: Orlando, FL 32806

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

I understand that this authorization expires a year from signed date.

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____