FLORIDA Primary Care & Sports Medicine Sports Med

Florida Primary &

140 Pinnacles Drive
Palm Coast, FL 32164
(386) 313-6035

Notice and Acknowledgement

I acknowledge that I have received that attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

If applicable, personal representative relationship: _____

HIPAA Right of Access for Family Member/Friend

I, _____, direct my health care and medical services providers to disclose and release my protected health information described below to:

Name: _____Relationship: _____
Contact information: _____
_____

Health Information to be disclosed upon the request of the person named above –

(Check either A or B):

□A. **Disclose my complete health record** (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

OR

□B. **Disclose my health record, as above, BUT do not disclose the following** (check as appropriate):

□Mental health records
□Communicable diseases (including HIV and AIDS)
□Alcohol/drug abuse treatment
□Other (please specify): _____