**Last name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the following entity to release/receive my (PHI) Protected Health Information:

**To / From To / From**

Hawthorne Clinic and Research Center Individual, Facility, Organization and address

2068 Hawthorne Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suite 201 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sarasota, Florida 34239 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Disclose to self**

**Purpose of Disclosure:**

□ Continuing Care □ Payment of claim □ School □ Legal □ Personal use □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released:**

□ Progress Notes □ Lab work □ Pathology Results □ Operative Notes □ Allergy testing □ Other testing

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Understanding:**

* I understand the expiration date of this request is 1 year from date signed.
* I understand I may revoke this authorization at any time by providing the Hawthorne Clinic and Research Center in writing, and it will be in effect the date notified, except to extent of action already been taken.
* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer be protected by Federal privacy regulations.
* I understand that I may be required to pay and administrative fee for retrieval and photocopying of records.

*(Cost: $1.00 a page for the first 25 pages and .25 for every page thereafter)*

* I understand that my medical information may include information related to sexually transmitted disease, AIDS, HIV status, mental health and drug or alcohol use.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_