Health Partners LLC

3107 Sawgrass Village Circle, Ponte Vedra Beach, FL 32082
Phone (904) 373-0942 Fax (904) 395-9018

AUTHORIZATION TO USE and ACCESS "PROTECTED HEALTH INFORMATION"

PURPOSE: This authorization is at my request to permit Health Partners LLC to respond to inquiries regarding Protected Health Information regarding any or all medical information related to my care at Health Partners LLC.

SECTION I (Please provide the following information regarding the person whose Protected Health Information is to be released.)

Patient Name (please print): _____

Date of Birth: _____

SECTION II
I authorize Health Partners LLC to release, orally and/or in writing, the following Protected Health Information concerning me: Identifying information (e.g., name, address, age, gender); Health care coverage information (i.e., general & plan-specific benefit information); Past, present and future claims information (except for any period of time during which a Confidential Communication address was in effect); and Coordination of Benefit Information.

SECTION III (Please identify the person(s) to whom the patient's Protected Health Information may be released and their relationship (i.e., sales agent, employer health benefit representative, parent, family, patient, friend, etc.) My information may be given to the person(s) listed below.
Please Print:
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

SECTION IV
By law, this authorization must indicate that persons other than Health Partners LLC receiving patient's Protected Health Information may not have to obey federal health information privacy laws and patient's Protected Health Information may be further released by those persons. I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, Health Partners LLC will have no further liability as to the further release of my Protected Health Information by those designated persons.
This authorization is voluntary and is not a condition of enrollment in a health plan, eligibility for benefits or payment of claims.

Please see next page

SECTION V
This authorization will expire: _____//_____//_____ (Month Day Year)

OR The date patient notifies Health Partners LLC in writing that the authorization will expire.
*It is advised that you place a specific expiration date on this authorization if you are designating a sales agent or employer as an authorized representative, or any other person for whom you may have designated to assist you with a specific, short-term task.

SECTION VI
Copy of Authorization
Please keep a copy of your signed authorization. A photocopy is as valid as the original.

SECTION VII
Right to Withdraw Authorization
I understand that I may withdraw this authorization at any time by giving written notice to Health Partners LLC.

Section VIII
FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. Health Partners LLC reserves the right to charge a reasonable fee for copies of records requested from this office.

SECTION IX
Signature
Patient Signature: _____ Date: _____

If a legal representative signs this authorization form on behalf of the patient, please complete the following information:
Legal Representative's Name*: _____
Date Signed: _____
Relationship to the patient: _____
*Please provide written documentation to support your status as a guardian or other legal representative. _____