Florida Medical Clinic
Your Life. Our Specialty.
38135 Market Square
Zephyrhills, FL 33542

AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
DOB	Account #	

COMPLETE ONLY IF THE PERSON AUTHORIZING COMMUNICATION IS NOT THE PATIENT

Name of Representative	
Relationship to Patient (parent, health proxy, etc.)	Phone #
Email Address	

I AUTHORIZE FLORIDA MEDICAL CLINIC, PA TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:

METHOD	CONTACT INFORMATION
☐ TEXT	
☐ EMAIL	
☐ VIDEO CONFERENCE	

☐ I do not authorize Florida Medical Clinic, PA to communicate with me via electronic means

This Authorization to Communicate PHI via electronic means expires

☐Upon written revocation ☐Automatically one year from the date of signing

☐Another date/event:

I understand by selecting the method of communication above and signing below, I authorize Florida Medical Clinic, to share/communicate PHI information via electronic means to myself or my designated representative described above.

My signature on this Authorization indicates that I am giving permission for Florida Medical Clinic to communicate with me via the method checked above.

I understand Florida Medical Clinic may communicate to me information such as when I have an upcoming appointment, services recommended by my doctor (i.e. flu shot), medication refills, new services offered, financial information or statements and new locations/providers at Florida Medical Clinic.

I understand that according to HIPAA Privacy Rule § 164.501, Florida Medical Clinic cannot sell or distribute my communication method or information with any third-party without my prior consent.

I understand that, by federal law, the Florida Medical Clinic may not use or disclose my health information without my authorization, except as provided in Florida Medical Clinic's Notice of Privacy Practices.

I hereby release Florida Medical Clinic and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Signature	Date
Print Name:	Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative

Florida Medical Clinic, P.A.
Authorization to Verbally Share Protected Health Information

Patient Name:	Second Form of Identification (DOB/Account#)

I authorize FLORIDA MEDICAL CLINIC to verbally share protected health information with the following persons:

Last Name	First Name	Relationship	Phone #
1.			
2.			
3.			

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (Rx Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature _____ Date _____

FMC Personnel _____ Date _____