5315 Avion Park Drive, Suite 120, Tampa, Florida 33607
Phone: 844-650-5802 Fax: 844-277-0049

Patient Authorization for Specific Disclosure of Protected Health Information (PHI)

Name:_____**DOB:** _____

Address: _____ **Medical Record Number:**_____

City: _____**State:** _____ **Zip code:** _____

I_____ undersigned, hereby authorize provider and personnel at IV Solutions RX, to disclose all available protected health information to the following:

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____ Phone Number: _____

Additional Providers:

Name: _____ Specialty: _____

Phone: _____ Fax: _____

Name: _____ Specialty: _____

Phone: _____ Fax: _____

I understand:

- That this request does not apply to 1) Health information not held in the Provider's medical records, 2) psychotherapy notes, 3) information compiled in reasonable anticipation of or for litigation, and 4) other health information not subject to the right of access under HIPAA.
- I request that all information be disclosed for the purposes of allowing the above-named individuals to participate in my care and under my health and treatment plans.
- This authorization will expire in 10 years after the date of its execution, and I understand I can revoke permissions granted at any time.
- That my prescribing provider is authorized to my health information without signature of this disclosure.
- That this authorization does not limit the provider's ability to disclose my protected health information to a family member, or friend not listed above in accordance with HIPAA.
- That if my protected health information is disclosed to someone who is not required to comply with federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.
- That I may revoke this authorization at any time. However, if I revoke this authorization, it will have no effect on actions already taken by IV Solutions RX in reliance on this authorization.

I authorize the disclosure described herein. I have read and understood the authorization. I am the patient listed on this authorization or am a medical power of attorney or authorized representative to act on the behalf of the patient.

Patient or Legal Guardian Signature: _____Date:_____

Printed Name of Patient or Legal Guardian: _____