James K Shea MD INC

PO Box 547729, Orlando FL 32854
407-422-0200
Fax 407-901-3536

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(SEND James K Shea MD Inc. RECORDS TO INDICATED PERSON/ORGANIZATION)

I hereby authorize James K Shea MD Inc. to disclose my individually identifiable Protected Health Information ("PHI") as described below.

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to James K Shea MD Inc. I understand that federal law protects my PHI. However, my information could be shared with agencies or businesses that may not be covered by the federal law. They could then share my information with others.

Patient Name_____ Account/Case Number_____

PERSONS / ORGANIZATIONS AUTHORIZED TO RECEIVE MY PHI:

Doctor _____
Name **Address**
_____
Phone **Fax**

Insurance_____
Name **Address**
_____
Phone **Fax**

Attorney _____
Name **Address**
_____
Phone **Fax**

Emergency Contact _____
Name **Address**
_____
Phone **Fax**

Other _____
Name **Address**
_____
Phone **Fax**

Specific description of information to be disclosed:
□ Medical Records (all dates)_____ □ Psychotherapy Records (all dates)_____ □ Other (all dates)_____
Specific purpose of the disclosure(s) □ Law Enforcement □ Attorney □ Physician □ Other

Important Information About Your Rights

I have read and understood the following statements about my rights:
1. I do not have to sign this authorization in order to obtain health care.
2. I may revoke this authorization at any time prior to its expiration by notifying James K Shea MD Inc. in writing: but the revocation will have no effect on any actions the entity took before receiving the revocation. (If you have any questions regarding revocation, please refer to the Notice of Privacy Practices).
3. I may see and copy the information described on this form, if I ask for it.
4. The information authorized to be disclosed may be re-disclosed by the receiving entity, at which time it may no longer be protected under privacy laws.
5. James K Shea MD, INC. may exercise its right to charge me a reasonable fee for copying and processing this information.

_____
Signature of Patient or Patient's Representative Date (***Authorization will expire 6 years from this date)***

Name of the Patient's representative (please print)_____

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

(SEND MEDICAL RECORDS TO James K Shea MD INC)

HIPAA AUTHORIZATION FORM

I, _____

Patient Name Patient Address

_____

Patient Date of Birth Patient Social Security Number

give permission to:

_____

Name and address of health provider or entity to release this information

_____

_____

to:

☐ use the following protected health information, and/or
☐ disclose the following protected health information to:

James K Shea MD INC

PO Box 547729, Orlando FL 32854
407-422-0200
Fax 407-901-3536

Information to be disclosed (check all that apply):

☐ Medical Records
☐ Treatment Records
☐ Diagnostic Records
☐ Other: _____

Include: (indicate by initialing)
[Disclosure of Alcohol/Drug treatment, Mental Health Information, or HIV-related Information is not authorized unless initialed]

_____Alcohol/Drug Treatment
_____Mental Health Information
_____HIV-Related information

This protected health information is being used or disclosed for the following purposes:
_____Medical treatment/medical evaluation_____
_____
_____

This authorization expires in one year unless otherwise indicated.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

You may inspect or copy the protected health information to be used or disclosed under this authorization.

Finally, you may revoke this authorization in writing at any time by sending written notification to ***James K Shea MD Inc. attn: Danielle Shea*** at ***PO Box 547729, Orlando FL 32854*** Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name Relationship/Authority