HARBOR PHYSICIANS
Primary Care & Internal Medicine
2140 Kingsley Ave, Suite 1, Orange Park, FL 32073
Ph: 904-368-6809 | Fax: 904-368-6809

HARBOR PHYSICIANS – PRIMARY CARE & INTERNAL MEDICINE
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
(HIPAA-Compliant Release Form)

PATIENT INFORMATION
Patient Name: _____
Date of Birth: ____ / ____ / _____
Address: _____

AUTHORIZATION TO RELEASE FROM (Disclosing Provider/Facility)
Clinic: Harbor Physicians – Primary Care & Internal Medicine |2140 Kingsley Ave, Suite 1, Orange Park, FL 32073
RELEASE TO (Recipient)
Name/Organization: _____
Address: _____
Phone/Fax: _____

PURPOSE OF DISCLOSURE
☐ Treatment / Continuity of Care ☐ Insurance / Payment ☐ Disability / Legal ☐ Personal Use
☐ School / Work ☐ Other: _____
INFORMATION AUTHORIZED FOR RELEASE (Check all that apply)
☐ Entire Medical Record ☐ Office Visit Notes ☐ Problem List / Diagnoses ☐ Medication List
☐ Lab Results ☐ Imaging / Radiology Reports ☐ Immunizations ☐ Hospital / ER Records ☐ Billing Records ☐ Other (specify): _____
Date Range (if applicable): From ____ / ____ / _____ to ____ / ____ / _____
SENSITIVE INFORMATION (Optional – must be specifically authorized)
☐ HIV/AIDS Related Information ☐ STD/STI Information ☐ Mental Health Records (non-psychotherapy notes) ☐ Substance Use Disorder Treatment Records ☐ Psychotherapy Notes (requires separate authorization in most cases)
EXPIRATION OF AUTHORIZATION
☐ 1 year from date of signature ☐ On specific date: ____ / ____ / _____
PATIENT RIGHTS & ACKNOWLEDGEMENT
I understand that I may revoke this authorization at any time in writing, except where action has already been taken.
I understand that information disclosed may no longer be protected under HIPAA once released to the recipient.
I understand that signing this form is voluntary and will not affect my treatment, payment, or eligibility for care.
Patient/Legal Representative Name: _____
Signature (wet): _____
Date: ____ / ____ / _____
Relationship to Patient (if applicable): _____
Witness Signature (if required): _____
Date: ____ / ____ / _____

OFFICE USE ONLY
Date Received: ____ / ____ / _____
Processed By: _____
Method of Release: ☐ Fax ☐ Mail ☐ Secure Email ☐ Portal ☐ Other _____
Date Sent: ____ / ____ / _____