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

Patient Name: _____ DOB_____

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Authorized Person(s)
I authorize Harbor Physicians to communicate with and release my protected health information (PHI) to the individual(s) listed below (if any).

☐ I do NOT authorize Harbor Physicians to release my PHI to any individual. I understand that I am choosing not to designate any authorized person.

Name: _____
Relationship: _____
Phone Number: _____

(Additional names may be listed if applicable)

Information Authorized for Release
This authorization includes, but is not limited to: appointments, billing/insurance information, medical records, lab/test results, and other related healthcare information.

Expiration
This authorization expires one (1) year from the date signed, unless otherwise specified below.

Other expiration date: _____/ _____/ _____

Signature Patient or Representative Signature: _____
Printed Name: _____
Relationship: _____
Date: _____/ _____/ _____
