

Ivan L. Mazzorana, Jr. M.D., P.A.
12590 Whitehall Drive
Suite #3
Fort Myers, Florida 33907
Phone: (239) 939-9090 Fax: (239) 939-2922

Authorization to Disclose Protected Health Information

Pursuant to Health Insurance Portability and Accountability Act (HIPPA), I

_____ hereby authorize
(Print your name & SSN)

(Provider/Facility)

(Address)

(Tel/Fax)

To use or disclose the following protected health information from my medical record as instructed by me:

- The entire medical record
- Specific parts of the medical record

This information is to be disclosed to:

(Provider/Facility)

(Address)

(Tel/Fax)

I understand that I may revoke this authorization, at any time, by writing to the Privacy Officer, at which time it will go into effect. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or state law. Unless otherwise revoked, this authorization will expire on 1 year. The facility, its Employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

I fully understand and accept the terms of this information.

Patient/Legal Representative Signature

Date