

**SHANDS HEALTHCARE
SHANDS MEDICAL GROUP
@ MAGNOLIA PARKE
4740 NW 39TH PL STE B
GAINESVILLE, FLORIDA 32606**

**AUTHORIZATION
FOR
DISCLOSURE OF INFORMATION, TO FAMILY MEMBERS OR DESIGNATED REPRESENTATIVE**

As required by the Health Insurance Portability Act of 1996, you have the right to request that we restrict use and disclosure of your health information with respect to treatment, payment and healthcare operations. You may also restrict disclosures to your family, relatives or close personal friends or others you identify who are involved in your care or payment for your care. We will abide by your agreement until either of us terminates this agreement. Note: All restriction requests must be approved by the Privacy Officer or their designee.

(HIPPA Policy 45 CFR 164.510(b)(1)(I))

Note: By law, this restriction will not apply with respect to information necessary to provide emergency treatment.

By signing this document you are granting permission for your physician to discuss your health information with the party/parties that you designate. This permission for disclosure will remain in effect until ____/____/____, or I may revoke it prior to this expiration at anytime but I understand I must do so in writing.

I, _____, grant permission for my physician,

_____ M.D. to discuss my health information or release health information to the following designee to assist in my medical care, treatment, or payment of services.

NAME OF DESIGNEE

RELATIONSHIP TO PATIENT

_____	_____
_____	_____
_____	_____

Restrictions to information that may be released:

I do not want my medical information discussed or disclosed to a family member or patient representative except in an emergency situation.

You may leave messages for me regarding my medical care on my answering machine or voice mail.

I do not want messages left on answering machine or voice mail.

SIGNED _____
DOB: ____/____/____

Date ____/____/____

Date Privacy Officer/designee notified ____/____/____

Name of Officer or designee _____

Signature _____