Primary Care Medical Center, PLLC

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HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

Primary Care Medical Center of Gulfport, PLLC herein referred to as PCMC.

I hereby authorize PCMC and its affiliates, its employees and agents, to release to

☐ **SPOUSE**_____

☐ **FAMILY**_____

☐ **OTHER**_____

☐ **INFORMATION IS NOT TO BE RELEASED TO ANYONE.**

my or my legal dependents personal health information maintained by PCMC (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided and which identifies me or my legal dependents name, address, social security number, member ID number) except the following information

_____

_____

for legal proceedings, law enforcement, abuse, neglect or public health safety or for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above my be subject to re-disclosure by such person or organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my or my representative's signature below. I understand that I have the right to revoke this authorization by providing written notice. However, this authorization may not be revoked if PCMC, its employees or agents have taken action on the authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Messages

Please call my: ☐ home ☐ work ☐ cell Number: _____ or notify me by email.

My email_____

If unable to reach me: ☐ you may leave a detailed message ☐ leave a message asking me to return your call ☐ send an email

The best time to reach me is (day)_____between (time)_____
I understand that only under normal conditions will I be left any messages or sent any emails. I also understand that I cannot schedule my office visit using email.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Dated _____ Signature _____

SSN _____ Print Name _____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Dated _____ Legal Representative Name _____
Legal Representative Signature _____

Dated _____ Witness Name _____

Witness Signature _____