OSCEOLA PHYSICIAN MANAGEMENT
Dr. Mark Round, MD, FACP

NEW PATIENT PACKET

ABOUT OUR PRACTICE

OFFICE HOURS:

MON-THURS 8:30am - 5:00pm
FRIDAY 8:30am - 12:00pm

CLOSED DAILY FROM 12:00pm - 2:00pm for Lunch

INTERACTIVE PATIENT PORTAL

healow
Health and Online Wellness

PRACTICE CODE: CDHIBA

THIS SERVICE ALLOWES PATIENTS TO:

- Access medical summaries
- Request Refills of medications
- Make Appointments
- Update Information
- Ask questions to our providers and staff

This is our preferred method of communication. It provides a faster turnaround time for refills and questions, it also creates a record of the communication directly in your chart.

PRESCRIPTIONS AND REFERRALS

If you need a **PRESCRIPTION REFILL**, please allow up to **72 business hours to process** your refill request as this is our office policy.
If you need a **REFERRAL**, please allow up to **7-10 business days to process** your referral request as this is our office policy.

FINANCIAL AND OFFICE POLICIES

Payment is expected at the time of service.
Co-pays, co-insurance, deductibles, are all due at the time of service.

YOU ARE RESPONSIBLE to know and understand what your insurance plan will or will not cover.
We ask that you reschedule your appointment if you are unable to pay your financial responsibility at the time of service, this INCLUDES past due balances.
We will assess a **$35 service fee** for any returned checks from the bank.
Past Due Balances are due **PRIOR** to making another appointment.

CANCELLED OR MISSED APPOINTMENTS

If you need to **cancel an appointment**, contact us at least **24 HOURS PRIOR** to your appointment time, if you contact us within 24 hours of your appointment time there will be a **$35 fee** billed to you.

If you **miss an appointment**, and do not call you will have a **$35 fee** billed to you.

APPOINTMENT REMINDERS

We use automated and electronic systems for appointment reminder. **By signing below, you authorize** our agents to contact you using any contact information you provide us including email addresses and wireless phone numbers.
I **agree** to the above terms of Mark Round M.D., **I am responsible for any balances due on my account.**

Signature: ________________________________ **Today's Date:** ___/___/______

Print Name: ________________________________ **Date of Birth :** ___/___/______

Dr. Mark Round

Dr. Mark Round

More Information :

203 Park Place Blvd, Kissimmee, FL 34741
(407) 933-7119
(407) 933-7732
www.ROUNDMD.com

THANK YOU

OSCEOLA PHYSICIAN MANAGEMENT
Dr. Mark Round, MD, FACP

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Dr. Mark Round

Dr. Mark Round

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THANK YOU

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NEW PATIENT PACKET

PATIENT REGISTRATION

Full Name* : ____________________

Social Security Number* : ____________________

Date of Birth* : ______ / ______ / ______ **Gender*** : ☐ Male ☐ Female

Address* : ____________________

____

Cell Phone #* : ____________________ **E-Mail*** : ____________________

Other Contact # : ____________________ **Other Contact #** : ____________________

Status* : ☐ Single ☐ Married ☐ Divorce ☐ Others

Spoken Language : ____________________ **Ethnicity** : ____________________

Race : ____________________ ☐ Check this box, if you decline to share this information.

EMERGENCY CONTACT

Contact Name* : ____________________ **Mobile Number*** : ____________________

Relationship* : ____________________ **Home/Work Number** : ____________________

EMPLOYER INFORMATION

Occupation* : ____________________ **Are You A Retiree ?** : ☐ Yes ☐ No

Employer Name* : ____________________ **Mobile Number*** : ____________________

Address* : ____________________

____

INSURANCE INFORMATION

Insured Person's Name*: ____________________ **Contact Number*** : ____________________

Relationship to Patient*: ____________________

Address* : ____________________
If different from employer address
____

Medicaid # (If applicable): ____________________ **Medicaid # (If applicable)**: ____________________

Primary Insurance Company Name : ____________________

ID Number : ____________ **Group Number**: ____________ **Tel #** : ____________

Secondary Insurance Company Name : ____________________

ID Number : ____________ **Group Number**: ____________ **Tel #** : ____________

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PATIENT REGISTRATION

PHARMACY INFORMATION

Primary Pharmacy Name* : ______________________________

Address* : ______________________________

____

Contact Number : ______________________________

Secondary Pharmacy Name (If Applicable) : ______________________________

Address : ______________________________

____

Contact Number : ______________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS

I hereby **authorize all medical or surgical benefits**, to include major medical benefits which I am entitled, including Medicare, private insurance and any other health plans to **Osceola Physician Management Inc**. (203 Park Place Blvd, Kissimmee, FL 34741). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible**, after 90 days, for all charges whether paid or not paid by my insurance carrier. **I hereby authorize** said assignee to release all information necessary to secure payment. It also authorizes release of complete medical records concerning my illness and/or treatment to said assignee or other medical providers and institutions that may become involved in my diagnosis and treatment.

Signature: ____ **Today's Date:** ___/___/_______

Print Name: ____

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NEW PATIENT PACKET

ADVANCED CARE PLANNING

DECLARATION TO DECLINE LIFE PROLONGING PROCEDURES (LIVING WILL)

☐ I **HAVE** made a Living Will

☐ I do **NOT** have a Living Will

HEALTH CARE SURROGATE

☐ I **HAVE** designated a Health Care Surrogate

☐ I have **NOT** designated a Health Care Surrogate

HealthCare Surrogate Name*: ______________________________

Contact Number* : ________________________

Relationship to Patient*: ______________________________

Address* : ____

____

DURABLE POWER OF ATTORNEY

☐ I **HAVE** appointed a Durable Power of Attorney for Health Care decisions.

☐ I have **NOT** appointed a Durable Power of Attorney for Health Care decisions

Power of Attorney Name*: ______________________________

Contact Number* : ________________________

Relationship to Patient*: ______________________________

Address* : ____

____

Signature: ___________________________________ **Today's Date:** ___/___/______

Print Name: ___________________________________ **Date of Birth :** ___/___/______

If you have **any further questions**, you can **contact** your Family Attorney, Local Hospital or Local Medical Association for additional information.

Last Name: ___________________
First Name: ___________________
Date of Birth : ___/___/_______
Today's Date: ___/___/_______

NEW PATIENT PACKET

PATIENT HISTORY FORMS

REVIEW OF SYSTEMS

Do you know or have had any problems relating to the following systems?
Circle Yes or No

CONSTITUTIONAL		
Weight Change	Y	N
Chills	Y	N
Sleep Disorder	Y	N
Other	Y	N

GENITOURINARY		
Change in Stream	Y	N
Nocturnal (getting up at night	Y	N
Urinary frequency > 8 times/day	Y	N
Other	Y	N

EYES		
Double Vision	Y	N
Glaucoma	Y	N
Cataracts	Y	N
Other	Y	N

MUSCULOSKELETAL		
Bone Pain	Y	N
Muscle Pain	Y	N
Joint Pain	Y	N
Other	Y	N

EAR/NOSE/THROAT/MOUTH		
Hearing Changes	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other	Y	N

INTEGUMENTARY (SKIN)		
Rash	Y	N
Lumps or Bumps	Y	N
Moles, Skin Tags	Y	N
Other	Y	N

CARDIOVASCULAR		
Chest Pain	Y	N
Irregular Heartbeat	Y	N
High Blood Pressure	Y	N
Other	Y	N

NEUROLOGICAL		
Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other	Y	N

PSYCHOLOGIC		
Are you generally happy?	Y	N
Do you feel depressed?	Y	N
Do you feel anxious?	Y	N
Do you feel safe at home?	Y	N

RESPIRATORY		
Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other	Y	N

ENDOCRINE		
Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other	Y	N

GASTROINTESTINAL		
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other	Y	N

HEMATOLOGIC/LYMPHATIC		
Swollen Glands	Y	N
Blood Clotting Problem	Y	N
Bruising	Y	N
Other	Y	N

SEXUAL HISTORY		
Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N
Other (i.e. sexual trauma)	Y	N

ALLERGIC/IMMUNOLOGIC		
Hay Fever	Y	N
Drug Allergies	Y	N
Food	Y	N
Other	Y	N

LAST EYE & DENTAL EXAM

Date of Last Eye Exam : ___/___/_______

Date of Last Dental Exam : ___/___/_______

Last Name: ____________________
First Name: ____________________
Date of Birth : ___/___/______
Today's Date: ___/___/______

NEW PATIENT PACKET

PATIENT HISTORY FORMS

REVIEW OF SYSTEMS COMMENTS/CONCERNS

____
____
____
____
____

MEDICAL HISTORY

MEDICAL

(High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)

☐ Check here if none

Year	

SURGICAL

(Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

☐ Check here if none

Year	

PREGNANCY HISTORY

☐ Check here if none

Year	Sex	Complications

Last Name: ____________________
First Name: ____________________
Date of Birth : ___/___/______
Today's Date: ___/___/______

NEW PATIENT PACKET

PATIENT HISTORY FORMS

MEDICAL HISTORY

CURRENT PRESCRIPTION MEDICINES

☐ Check here if none

Name of Drug	Mg Dose	# Tablets	# times per day

Over the Counter Medications
Aspirin, Tylenol, Ibuprofen, Aleve, Vitamins, and Herbals
____
____
____

☐ Check here if none

DRUG ALLERGIES

____
____
____

FAMILY HISTORY

Father ☐ **Living** Age: ____ ☐ **Deceased** Age of Death: ____ **Cause:** ________________

Mother ☐ **Living** Age: ____ ☐ **Deceased** Age of Death: ____ **Cause:** ________________

Sibling(s) # of Living: ______ # of Deceased: ______ **Cause:** ______________________________

List other illnesses in your family (Diabetes, heart disease, cancers, etc.)

Family Member	Illness	Family Member	Illness

Last Name: ___________________
First Name: ___________________
Date of Birth : ___/___/_______
Today's Date: ___/___/_______

SOCIAL HISTORY

Smoke? ☐ **Yes** ☐ **No** If yes, how much? __________ # of packs a day ________

When did you stop smoking? ____/____/______

Alcohol? ☐ **Yes** ☐ **No** If yes, how much? __________

Domestic Violence? ☐ **Yes** ☐ **No** Comments, if any ____

Exercise Regularly? ☐ **Yes** ☐ **No** If yes, what and how frequently? __________________________________

Routinely wear seatbelts? ☐ **Yes** ☐ **No** **Routinely wear helmets?** ☐ **Yes** ☐ **No**

OSCEOLA PHYSICIAN MANAGEMENT
203 Park Place Blvd, Kissimmee, FL 34741
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(407) 933-7732
www.ROUNDMD.com

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 7-10 business days for copying.
The medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT

Step 1: Patient Name*: ____ **Date of Birth*:** ____/____/_______

Address*: ____

____

Step 2: I hereby authorize **OSCEOLA PHYSICIAN MANAGEMENT** ______ to release ______ to obtain my health information.

Name of Physician/Medical Facility*: ____

Address*: ____

____

Phone Number*: (____) _____ - _______ **Fax Number*: (____) _____ - _______**

Step 3: Information to be released: ____
Date(s)/Condition(s)

______ Transferring out of practice Reason:____
(This section must be completed before records will be released)

______ 2nd Opinion/will be continuing care with the practice.

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing.
If I do, it **will not affect any previous actions already taken** in reliance upon my authorization.
I may not be able to revoke this authorization if its' purpose was to obtain insurance.
I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.
Information used or disclosed pursuant to this Authorization **may be subject to re-disclosure** by the recipient and no longer protected by Federal privacy regulations.
*This authorization is valid for 90 days for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from them.*

Signature: ____ **Today's Date:** ___/___/_______

Print Name: ____

FOR THE PURPOSE(S) OF (ALCOHOL & DRUG ABUSE CLIENTS ONLY)

This is _______ single disclosure or _______ a continuing disclosure for 90 days. (Check one)

Date on which consent was given: ____/____/_______

Release Expiration Date: ____/____/_______

CONSENT IS SUBJECT TO REVOCATION AT ANY TIME.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition(s) and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be discussed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office, In addition, we may use a sign-in sheet at the front registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary; to contact you and remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by law, Public Health Issues as Required by Law, Communicable Diseases: Health oversight: Abuse or neglect: Food and Drug Administration requirements: legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law. You may receive this authorization at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on file use or disclosure indicated in the authorization.

Print Name: ________________________ **Date of Birth :** ___/___/______

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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is **NOT** required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to have your physician amend your protected health information, if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw any information provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our hipaa Compliance Officer in person or by phone at our Main Phone Number (Listed in the top left corner).

A signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Signature: ____ **Today's Date:** ___/___/______

Print Name: ______________________________________ **Date of Birth :** ___/___/______

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AUTHORIZATION TO RELEASE OR USE INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I _________________________, **DOB**: ____/____/_______ hereby authorize the release or use of my individually identifiable health information ("Protected Health Information") and medical record information by **Osceola Physician Management** in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for more information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy pf the revised notice.

I acknowledge and agree that the Practice can disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates or have power of attorney on my behalf:

Full Name	Relationship to Patient	Contact Number
______________________	______________________	(____) _____ - _______
______________________	______________________	(____) _____ - _______
______________________	______________________	(____) _____ - _______
______________________	______________________	(____) _____ - _______

Please explain the above Representative's authority to act on behalf of the patient:

____

____

____

I agree that the practice may also disclose the following information contained in my medical records (Please initial the appropriate categories listed below):

_______ **HIV/AIDS Information** _______ **Substance Abuse Information**

_______ **Mental Health Information** _______ **Sexually Transmitted Disease Information**

_______ **If Patient is under the age of eighteen (18), Pregnancy Information**

I agree and consent to the Practice releasing information to me in the following alternative manner(s) (Please initial in the appropriate spaces below, and please select more than one manner):

_______ **Via regular mail with envelopes being marked personal and confidential and addressed to me.**
_______ **Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and a unique personal identifier).**
_______ **Via email to my designated email address, which is ______________________________**

Print Name: ______________________________ **Date of Birth :** ___/___/_______

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AUTHORIZATION TO RELEASE OR USE INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

At all times, you can retain the right to revoke this consent. Such a revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The practice may refuse to treat you if you (or an authorized representative) do not sign this consent form. If you (or an authorized representative) sign this consent and then revoke it, the Practice has the right to refuse to provide further treatment to you at the time of the revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and fully understand the information in this consent. I have received a copy of this consent, and I am the patient or authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Signature: ____ **Today's Date:** ____/____/_______

Print Name: ______________________________________ **Date of Birth :** ____/____/_______

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING****

Patient (name and information of person whose health information is being disclosed):

Name (First,Middle,Last): ____

Date of Birth: ___/___/______

Address (Street,City,State,Zip): ____

____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [see page 15 for details]

FROM WHOM: All information sources [see page 15 for details]

TO WHOM: OSCEOLA PHYSICIAN MANAGEMENT

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to **Osceola Physician Management.**

In Addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [see page 15 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosure above from the types of sources listed.**

Signature: ________________________________ **Today's Date:** ___/___/______

Print Name: ________________________________ **Date of Birth :** ___/___/______

Print Name of Legal Representative: ________________________________
(if applicable)

Relationship to Patient: ________________________________
(if applicable)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you

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EXPLANATION OF FORM FLORIDA AHCA FC4200-004

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"OF WHAT": Includes **ALL YOUR HEALTH INFORMATION**, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in hipaa at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis.
   f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height and weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"FROM WHOM": Includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records and administrators, counselors, etc.), managers, worker's compensation programs, state Medicaid, Medicare and any other governmental programs.

"TO WHOM": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"PURPOSE": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"REVOCATION": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"RE-DISCLOSURE OF INFORMATION": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form for Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.