Community Health Centers, Inc.
110 S Woodland St
Winter Garden, FL 34787
(407) 905-8827 (352) 314-7400
WWW.CHCFL.ORG

Patient Authorization to Use or Disclose Protected Health Information

Name of Patient (Type/Print) Date of Birth

Address City State Zip

Please Select Location/Fax Number:

☐ Apopka Family – (407) 886-4282
☐ Apopka Children – (407) 886-3822
☐ Bithlo – (321) 221-2043
☐ Forest City – (407) 660-1667
☐ Lake Ellenor – (407) 855-8882
☐ Leesburg – (352) 360-0762
☐ Meadow Woods – (321) 221-1057
☐ Pine Hills – (407) 209-3220
☐ Groveland – (352) 429-5606
☐ Tavares – (352) 742-3264
☐ Winter Garden – (407) 654-4079

Authorizes the Release of Protected Health Information To CHC From:

Name of Health Care Provider/Plan/Other Phone Number Fax Number

Address City State Zip

Information To Be Released:

☐ Medical History Examination, Reports
☐ Treatments or Tests
☐ Immunizations
☐ X-ray Reports
☐ Laboratory Reports
☐ Consultations
☐ Prescriptions
☐ Hospital Records and Reports
☐ Entire Record
☐ Other (Specify): _____

Purpose Of Disclosure (Check Appropriate Categories):

☐ Further Medical Care ☐ Changing Physicians ☐ Other (Specify): _____

In compliance with Florida Statutes, which requires special permissions to release otherwise privileged information, please release records pertaining to (Initials required):

_____ HIV/AIDS
_____ STD
_____ Mental or Psychological Health
_____ Drug, Alcohol and/or Substance Abuse
_____ Genetic Diseases/Tests (DNA)

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above or otherwise required by law. The authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, by sending a written request to CHC's Privacy Officer, and that I have the right to a copy of this authorization form. Privacy Officer, Community Health Centers, Inc., 110 South Woodland Street, Winter Garden, Florida 34787.

Patient/Parent/Legal Representative (Signature) Date of Authorization

Translator/Interpreter Address Phone Number

If Not Patient, State Relationship To Patient Or Authority To Sign Identification Presented