FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

HIPAA/Disclosure/Authorization

The Health Insurance Portability and Accountability Act (HIPAA) is a U.S. law designed to protect your private health information.

Please provide the following information to assist First Physicians Group in ensuring your personal health details are shared only with those you authorize.

Patient Name (please print) : _____ _____ _____
(First Name) (Last Name) (Date of Birth)

I give permission for First Physicians Group to share ***information*** with the following person(s) listed below				Check all that apply		
Name	**Contact Number**	**Relationship**		**Appointment**	**Billing**	**Medical**

Please read and initial the following:

_____ I understand First Physicians Group will only share information with person(s) listed above.
_____ I understand that this form applies to ALL providers of First Physicians Group.
_____ I understand it is my responsibility to notify First Physicians Group of any changes.
_____ I understand this form expires and will no longer be honored by First Physicians Group one (1) year from the date signed.

Pediatric patients only:

_____ I understand pediatric patients will be seen only when accompanied by parent or legal guardian unless a valid *Designation of Health Care Surrogacy Form* is completed and on file with First Physicians Group.

Printed Name: _____ **Signature: _____**

Relationship to Patient: _____ **Date: ____/____/_____**