Diversity
HEALTH CENTER OF TAMPA BAY
David W. Lyter, MD, MPH

Authorization for Release of Protected Health Information

Patient Name: _____Date of Birth:___/___/_____

I authorize the release of my protected health information, for the purpose of ongoing medical care. Records to be released **BY:**

Name of Health Care Provider_____

Address_____

Phone:_____ Fax:_____

TO:

David W. Lyter, MD, MPH
Diversity Health Center of Tampa Bay
4302 N. Habana Ave., Suite 200 Tampa, FL 33607
Ph: 813-518-0881 Fax: 813-518-0882

TYPE OF RECORDS REQUESTED: Hospital____ Office/Clinic Visit____

Information to be RELEASED:

_____History and Physical
_____Discharge Summary
_____Office notes (last 3)
_____Emergency Dept. Records
_____Operative/Procedure Reports
_____X-ray and Diag. Imaging Reports
_____ HIV-related test results
_____ Drug/Alcohol Information
_____ Behavioral Health Information
_____ EKG/Cardiology Reports
_____ Pathology Reports
_____Lab Reports (dates)_____

Specific records requested: _____

Time frame of records requested: _____

MY RIGHTS

- I understand this authorization is voluntary. I may revoke this authorization at any time, provided I do so in writing and submit it to the Office Manager of this practice. The revocation will take effect when received.
- I am entitled to receive a copy of this Authorization.
- Unless otherwise revoked, this Authorization expires in six months from the date of your signature.

SIGNATURE

_____ Date: ___/___/____

(Signature of Patient/Legal Representative)

_____ _____

(Printed Name) Phone # (include Area Code)