EDWARD C. LAZO, M.D.
D.B.A. LAZO MEDICAL CENTER INC.

321 SE 29TH Place, Suite 200
Ocala, FL 34471
(352) 690-6813

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Edward C. Lazo, M.D. is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Edward C. Lazo, M.D., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set for below.

Description of the Information to be used or disclosed (check all that apply):

[ ] The patient's entire medical record

[ ] The patient's demographic information (check all that apply):
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race [ ] Other:_____

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Name(s) or class of person(s) that the patient's protected health information may be disclosed to (spouse, family members, etc. – must specify by name):

_____
_____
_____
_____

[ ] (Check if applicable) This authorization is to be used for our own use, and Edward C. Lazo, M.D., will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Edward C. Lazo, M.D. must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Edward C. Lazo, M.D. will accept written revocations of this authorization via:
[ ] Facsimile at this number (352) 690-6859.

ALL revocations must be sent to Edward C. Lazo, M.D. to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, Edward C. Lazo, M.D. can no longer use of disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.