MDY PRIMARY CARE MEDICINE, P.A.
MARGARET R. YEE, M.D.
102 Park Place Blvd.
Davenport, FL 33837
Phone (863) 422-0032
Fax (863) 422-3275

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Dr. Yee to use and or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Dr. Yee to use or disclose information to: (Please list the Name, Phone Number, and Relationship below)

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The following individually identifiable health information (specifically describes the information to be released, such as date(s) of service, level of detail to be released origin of information, etc.)

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This authorization will expire on ______________________________
(Expiration Date or Defined Event)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Dr. Yee has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Yee's Privacy Officer at the above address.

Signed by: ______________________________ ______________________________
(Signature of patient or Legal Guardian) (Relationship to Patient)

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Patient's Name Date

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Print name of Patient or Legal Guardian