Braden Clinic

Address: 5068 Annunciation Circle, Suite 111
Ave Maria, FL 34142
Phone: 239-867-4395
Fax: (239) 217-3662
Email: info@bradenclinic.com

Beau Braden, DO | Emily Walkey, MD | Anthony Musingo, PA-C | Rosemarie Dobrydney, ARNP

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:_____Relationship:_____
Contact Information: _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

☐A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

- ☐Mental health records
- ☐Communicable diseases (including HIV and AIDS)
- ☐Alcohol/drug abuse treatment
- ☐Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐An electronic record or access through an online portal
- ☐Hard copy

This authorization shall be effective until (Check one):

- ☐All past, present, and future periods, OR
- ☐Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R.