Latitude Clinic LLC

Disclosure of Medical Information Consent Form

Patient's First Name _____ Last Name _____Date of Birth _____

Address_____City _____ State_____Zip _____

I authorize the following disclosing party To disclose the following health information

_____ _____

The above party may disclose this health information to the following recipient:

Latitude Clinic LLC
2831 Ringling Blvd, Suite F220, Sarasota FL 34237
P: (941) 253-2530 F: (941) 303-8619 Email: (941) 303-8619

The purpose of this authorization is Authorization ends

___ At My Request for Continuity of Care Date_____

___ Other ____When Latitude Clinic is no longer providing my care

My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient Signature or Authorized Representative _____

If patient is unable to sign, please complete the following:

Name of Signing Authorized Representative Authority of representative to sign on behalf of the patient

_____. ___ Parent ___ Legal Guardian ___ Court Order