The Arthritis Center
of the Palm Beaches
Specializing in Non-Surgical Orthopedics

Authorization to Disclose Protected Health Information

I, ____, hereby authorize Brett R. Hutton, M.D., P.A.
(Patient's Name or Legal Representative)

to receive all copies of my medical records.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the express written consent of the patient or the patient's legal representative.

The Arthritis Center of the Palm Beaches is authorized to make the following disclosure:

○ Entire Health Records

○ Other ____

This information may be disclosed to and used by my physicians and the following individual (s):

○ Relative (s)

Name____ Relationship ____________________________________

Name____ Relationship ____________________________________

○ Other

____

Patient's Printed Name____ Date of Birth_________________
Patient's Signature ____ Date _______________________
Name of Legal Representative ____ Date _______________________
Signature of Legal Representative ____