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

Authorization to Disclose Protected Health Information

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

○ Other ____

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

○ Relative(s)

_______________________________________ Relationship _____________________________

_______________________________________ Relationship _____________________________

○ Other:

____

Patient's Printed Name ___________________________________ **Date of Birth** ____________

Patient's Signature ______________________________________ **Date** ___________________

Name of Legal Representative___________________________________ **Date**_______________

Signature of Legal Representative____