

Alessi Family Care  
9400 Bonita Beach Rd.#102  
Bonita Springs, Fl 34135  
Pho:239-992-5444  
Fax:239-992-1315

**Authorization of Disclosure of Protected Health Information by another covered entity for use by Alessi Family Care**

**Information to be Used or Disclosed**

Information to be obtained under this authorization includes:

\_\_\_\_\_  
\_\_\_\_\_

DR. \_\_\_\_\_  
PHONE : \_\_\_\_\_  
FAX: \_\_\_\_\_

**Purposes of Disclosure**

Information listed above will be disclosed for the following purposes:

\_\_\_\_\_  
\_\_\_\_\_

**Persons Authorized to use or disclose information**

Information listed above will be used or disclosed by:

Dr. Alessi  
\_\_\_\_\_  
Name of person/organization

**Persons to Whom Information may be disclosed**

Information described above may be disclosed to: Alessi Family Care

**Expiration Date of Authorization**

This authorization is effective through until further notice unless revoked or terminated by the patient or patient's personal representative.

You may revoke or terminate this authorization by submitting a written revocation to Alessi Family Care. You should contact the **Privacy Officer** to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

**Rights of the Individual**

You may inspect or request a copy of information that is used or disclosed under this authorization.  
You may refuse to sign this authorization.

**Effect of Refusing Authorization**

If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for purposes of treatment, payment, or supporting the day-to-day operations of the practice.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Representative to Patient