

PURPOSE: I authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once TENET FLORIDA PHYSICIAN SERVICES II, LLC discloses my health information to the recipient, TENET FLORIDA PHYSICIAN SERVICES II, LLC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that TENET FLORIDA PHYSICIAN SERVICES II, LLC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at TENET FLORIDA PHYSICIAN SERVICES II, LLC; except, however, if my treatment at TENET FLORIDA PHYSICIAN SERVICES II, LLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case TENET FLORIDA PHYSICIAN SERVICES II, LLC may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to TENET FLORIDA PHYSICIAN SERVICES II, LLC's Privacy Office at the address listed below. The revocation will be effective immediately upon TENET FLORIDA PHYSICIAN SERVICES II, LLC's receipt of my written notice, except that the revocation will not have any effect on any action taken by TENET FLORIDA PHYSICIAN SERVICES II, LLC in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact TENET FLORIDA PHYSICIAN SERVICES II, LLC's Privacy Office at:

Corporate Compliance & Privacy Office
Tenet Healthcare
14201 Dallas Parkway
Dallas, Texas 75254
E-mail: PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize TENET FLORIDA PHYSICIAN SERVICES II, LLC to use or disclose my health information in the manner described above.

Signature

Date

Note: if Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures.

Signature of Authorized Personal Representative

Relationship to Patient

Date