Family Practice of Suntree and Viera, P.A.

Frank G. Ditz
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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

PATIENT NAME: ____ DOB: _______________________

Social Security #:____ TELEPHONE #: _____________________________

Purpose of Release: ____

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I hereby authorize **Family Practice of Suntree and Viera PA**, to (_____) Release to **or** (**XXX**) Obtain From:

____ (___) Specialist or (___) Former PCP
NAME OF PHYSICIAN OR FACILTY

____ PHONE: _______________________
ADDRESS

____
CITY, STATE, ZIP

____
FAX

Any information, including diagnosis, lab results, x-rays results, EKG's, treatment and/or any other testing rendered to me during the following period.

(___) The past twelve (12) months, or
(___) Most recent office note and test results

I understand this is to include or disclosure of my individually, identifiable health information. And to include any Federal or stated protected information under Florida Statute 394.459, Psychiatric information, Florida stature 397.501 and FAC I0D-93.064 Humane Immunodeficiency Virus test results (HIV testing, AIDS and/or related conditions).

- I understand and direct that this authorization remains in effect until I revoke the authorization in writing, except to the extent that the action has already been taken.
- I understand that the information used or disclosed is pursuant to the authorization maybe subject to re-disclosure by the recipient and no longer be protected by HIPPA.
- I hereby release Family Practice of Suntree and Viera PA and the employees from any and all liability that may arise from the release of this information as I have directed.
- I understand that there is a fee associated with copying of my medical records and agree to pay said charges as provisioned by Florida statue 458.309

Signature: ____ Date: ________________
(Patient, parent or legal guardian if minor)
Relationship to patient if signed by personal representative: ____

Witness: ____ Date: ________________
(Staff signature)