ORMOND INTERNAL MEDICINE, LLC

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This Medical Records Release is made _____.

TO: _____
Person, Provider, or Facility

Address: _____

Fax: _____ Phone: _____
Include area code Include area code

PLEASE FORWARD THE INFORMATION TO:

ORMOND INTERNAL MEDICINE, LLC, 279 S. YONGE STREET, ORMOND BEACH, FLORIDA 32174
PHONE: 386-673-2133 **FAX: 386-673-2743**
***ATTENTION*: MELISSA W.**

I, _____, do hereby request the following information be
Print Full Name
released to Ormond Internal Medicine, LLC (information over the last two years.) Items with a blank must be initialed by the patient or legal representative and dated.

- ☐ Information regarding assessment, diagnosis, and treatment of my condition, concerns, disease.
- ☐ All Radiology – diagnostic images, reports, including but not limited to X-Rays and EKG tracings.
- ☐ All Lab Results
- ☐ Medication Lists
- ☐ Problem Lists
- ☐ Consult Notes
- ☐ Flowcharts
- ☐ Information related to treatment for mental health. _____ Date _____
- ☐ Information related to treatment for substance abuse. _____ Date _____
- ☐ Information pertaining to sexually transmitted disease, including HIV or AIDS
  _____ Date_____
- ☐ Information related treatment for Pain
- ☐ THE PATIENT IS IN THE OFFICE NOW – PLEASE FORWARD ALL INFORMATION ASAP
- ☐ THE PATIENT HAS AN APPOINTMENT ON _____ PLEASE FORWARD ALL INFORMATION ASAP
- ☐ Other – please specify: _____

Patient Signature: _____ **DOB:** _____

If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information is to be disclosed, you must provide documentation proving your legal authority to request this information. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Legal order appointing personal representative.

PRINT NAME: _____ SIGNATURE: _____
DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

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