Ocala Infectious Disease and Wound Center
2651 SW 32nd Place Ocala, FL 34471
Ocala, FL 34471

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:___________________________________ **Date of Birth:**_________________________

Phone: H)_______________________________________ **Phone: W)**_____________________________

Address:____ **City/State/Zip:**________________________

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_________________________________ **Facility Phone:**________________________

Facility Address:______________________________ **Facility Fax:**__________________________

City, State, Zip:_______________________________

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1) Reason for disclosure:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other

2) Specific information requested:

- ☐ 2 years prior form last date seen
- ☐ Dates Other:__________________
- ☐ Specific Information Requested: _____________

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This information will be disclosed to and used by the following organization:

OCALA INFECTIOUS DISEASE AND WOUND CENTER
2651 SW 32nd Place Ocala, FL 34471
Phone: 352-401-7552 Fax: 352-622-7945

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present to our receptionist. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X____ _________________________
Signature of Patient / Guardian/ or Authorized Representative Date

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Printed Name