AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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PH: (239) 262-3399 Fax: (239) 261-1189

Patient Name: ___________________________________ Date of Birth: ______________ Social Security Number: ___________________

Patient Address: ____

I hereby authorize (physician's name): ____

To disclose records obtained in the course of my evaluation and/or treatment to:

____

Disclosure will include: (check all that apply) ALL ( ) record information Dates: _______________________________

( ) History & Physical ( ) Lab Reports ( ) Operative Reports ( ) Radiology Reports

( ) Progress/Physician Notes ( ) Pathology Reports ( ) Other: ____

Please initial on each line below to include these specific records in this release. **I understand that failure to initial the three (3) items below indicates that I do not want or authorize those specific records released.**

_______ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.

_______ Records related to HIV testing and results and/or AIDS diagnosis or treatment, and or STIs.

_______ Psychiatric and/or psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including any narrative summaries, tests, social work assessment, medications, psychiatric examination, progress notes consultations, and/or treatment plans.

_______ Records related to Genetic testing and results.

I also understand the following:

I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for my health care provider to inform the requester that portions of the record have been withheld.

- This authorization shall remain valid unless revoked and will expire 1 year after signing. This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee the recipient will not redisclose my health information to a third party not subject to applicable federal and state law governing the use and disclosure of my health information.
- I understand that signing this authorization is voluntary and will not condition my treatment, payment, enrollment, or eligibility for benefits.

____ ____________________________

Signature of Patient or Substitute Decision Maker Date

____ ____________________________

If Substitute Decision Maker, state relationship If Substitute Decision Maker State reason

REASON FOR REQUEST:

_____ Moving out of State
_____ No Insurance
_____ New Patient
_____ Personal Records
_____ Transferring Care
REASON :_________________________________

METHOD OF DISCLOSURE:

______ Mail to above patient address
______ Mail to above provider
______ Electronic Transfer
______ Hand delivered to patient
______ Faxed to above provider

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HAND DELIVERED RECORDS

Signature of Completer _____________________________
Date: __________________________

___________________________________ ___________________
Pattient Signature Date