Alfred J. Rodriguez, M.D., P.A.
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ **who resides at** _____
In the city of _____ **in the state of** _____ **hereby authorize:**

Name: _____
Address: _____
City, St., Zip: _____

To disclose the following specific medical information by □ mail or □ fax to:

Name: _____
Address: _____
City, St., Zip: _____

From the Health Records of:

Patient's Name: _____
Date of Birth: _____ Social Security# _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges/payments _____ Records of all visits _____ Consultation Reports
_____ Progress Notes _____ Discharge Summary _____ History & Physical Exam
_____ Photographs, videotapes, digital or other images _____ Mental health and/or alcohol and drug abuse treatment
_____ Record of specific visit, specific dates include or are limited to:_____
_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc).
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
_____ Hepatitis Information
_____ All of the above
_____ Other (must be specific) _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Alfred J. Rodriguez, M.D., P.A, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining the authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Printed name of Patient/Patient's Representative Date

_____ _____
Signature of Patient/Patient's Representative Expiration date (if other than one year from date above)

_____ _____
Patient's personal representative's authority to act Witness Signature

There will be a $35.00 fee for copying and postage costs.

Please submit this to your current provider so we can have your records at the time of your consultation.