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AUTHORIZATION FOR THE REQUEST OF PATIENT'S HEALTH INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

I, _____ Hereby request and authorize the release of the following medical records from:

_____

_____

_____

Phone Number: _____ FAX Number: _____

☐ Hospital Abstract	☐ OP Report	☐ Consultation
☐ Labs	☐ Discharge Summary	☐ Pathology
☐ X-Ray Reports	☐ EEG Report	☐ Cardiology
☐ MRI Report	☐ Doctor's Office Notes	☐ Other _____

This release of information is for continuity of care unless otherwise noted: _____

My records may contain the following and **unless crossed out and initialed** I specifically authorize their release:

HIV Test Results (AIDS) _____	AIDS related records _____	Drug or alcohol records _____	Tuberculosis Records _____
STD Records _____	Mental Health Records _____	Pregnancy Records _____	

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient: _____

Pursuant to Florida Law and the Health Insurance Portability and Accountability Act of 1996 (HIP AA) privacy rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIP AA and may no longer be protected by HIP AA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released.

This authorization expires in 6 months unless another date is written here. _____

PLEASE FAX ASAP, this is for immediate patient care! ! FAX# 772-223-0960