FAMILY MEDICINE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for all record requests.

Family Medicine at DeBary
110 Pond Court | Suite 303 |DeBary, FL 32713-2782
PHONE 386-337-3525 FAX 386-337-3526

1. ____ I am requesting medical records from Family Medicine at DeBary

____ I am requesting medical records be sent to Family Medicine at DeBary at the address/fax listed

2. The Records are being (circle one) Sent to/Requested from:

PHYSICIAN or SPECIALIST _____

STREET ADDRESS _____

CITY/STATE/ZIP_____

PHONE _____ FAX _____

PATIENT NAME _____

DATE OF BIRTH _____ **PHONE** _____

ADDRESS _____

Covering the period(s) of health care:

FROM (Date) _____/_____/_____ **To** (Date)_____/_____/_____

3. Information for disclosure, if included in my records:

____ Complete Health Record
____ Visit Summary
____ History & Physical
____ Consultation Reports
____ Medications List
____ Progress Notes
____ Procedure Reports
____ EKG
____ Photographs, Videos, Digital or Other Images
____ Anesthesia Record
____ Diagnostic Imaging
____ Laboratory tests (please specify) _____
____ Other (please specify) _____

4. If applicable, I also give permission for the following to be disclosed (please initial)**:**

____ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
____ Behavioral Health Services / Psychiatric Care
____ Treatment for Alcohol and/or Drug abuse
____ Sexually Transmitted Diseases (STD)
____ Genetic Counseling / Testing

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. 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 review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

6. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

7. This facility, 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.

8. Fees for copies of medical records in paper or electronic onto disk to be charged in accordance with the State of Florida fee schedule and the actual cost of postage.

_____ _____/_____/_____
Signed: (Patient, Legal Representative, Parent or Legal Guardian) (Date)

ID Provided _____

Official Use Only
Name of Person Releasing Information & Date of Release:
_____
_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for all record requests.

Family Medicine at Longwood
225 W State Road 434 |Suite 203 | Longwood, FL 32750
PHONE 407-459-4360 FAX 321-316-4714

1. ____ I am requesting medical records from Family Medicine at Longwood

____I am requesting medical records be sent to Family Medicine at Longwood at the address/fax listed above.

2. The Records are being (circle one) Sent to/Requested from:

PHYSICIAN or SPECIALIST _____

STREET ADDRESS_____

CITY/STATE/ZIP_____
_

PHONE _____
FAX_____

PATIENT NAME _____

DATE OF BIRTH _____ **PHONE** _____

ADDRESS _____

Covering the period(s) of health care:

FROM (Date) _____/_____/_____ **To** (Date): _____/_____/_____

3. Information for disclosure, if included in my records:

____ Complete Health Record
____ Visit Summary
____ History & Physical
____ Consultation Reports

____ Medications List
____ Progress Notes
____ Procedure Reports
____ EKG
____ Photographs, Videos, Digital or Other Images
____ Anesthesia Record
____ Diagnostic Imaging
____ Laboratory tests (please specify) _____

____ Other (please specify) _____

4. If applicable, I also give permission for the following to be disclosed (please initial)

____ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
____ Behavioral Health Services / Psychiatric Care
____ Treatment for Alcohol and/or Drug abuse
____ Sexually Transmitted Diseases (STD)
____ Genetic Counseling / Testing

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ID Provided _____

Official Use Only

Name of Person Releasing Information & Date of Release:

_____

_____

FAMILY MEDICINE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for all record requests.

Family Medicine at Mount Dora
6909 Old Hwy 441 | Suite 300 |Mount Dora, FL 32757
PHONE 352-415-2636 FAX 352-729-4811

1. ____ I am requesting medical records from Family Medicine at Mount Dora

____I am requesting medical records be sent to Family Medicine at Mount Dora at the address/fax listed above.

2. The Records are being (circle one) Sent to/Requested from:

PHYSICIAN or SPECIALIST _____

STREET ADDRESS_____

CITY/STATE/ZIP_____
_

PHONE _____
FAX_____

PATIENT NAME _____

DATE OF BIRTH _____ **PHONE** _____

ADDRESS _____

Covering the period(s) of health care:

FROM (Date) _____/_____/_____ **To** (Date): _____/_____/_____

3. Information for disclosure, if included in my records:

____ Complete Health Record
____ Visit Summary
____ History & Physical
____ Consultation Reports

____ Medications List
____ Progress Notes
____ Procedure Reports
____ EKG
____ Photographs, Videos, Digital or Other Images
____ Anesthesia Record
____ Diagnostic Imaging
____ Laboratory tests (please specify) _____

____ Other (please specify) _____

4. If applicable, I also give permission for the following to be disclosed (please initial)

____ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
____ Behavioral Health Services / Psychiatric Care
____ Treatment for Alcohol and/or Drug abuse
____ Sexually Transmitted Diseases (STD)
____ Genetic Counseling / Testing

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FAMILY MEDICINE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for all record requests.

Family Medicine at Nona
10437 Moss Park Road| Orlando, FL 32832
PHONE 407-802-1100 FAX 407-802-1111

1. ____ I am requesting medical records from Family Medicine at Nona

____I am requesting medical records be sent to Family Medicine at Nona at the address/fax listed above.

2. The Records are being (circle one) Sent to/Requested from:

PHYSICIAN or SPECIALIST _____

STREET ADDRESS_____

CITY/STATE/ZIP_____
_

PHONE _____ FAX_____

PATIENT NAME _____

DATE OF BIRTH _____ **PHONE** _____

ADDRESS _____

Covering the period(s) of health care:

FROM (Date) _____/_____/_____ **To** (Date) _____/_____/_____

3. Information for disclosure, if included in my records:

____ Complete Health Record
____ Visit Summary
____ History & Physical
____ Consultation Reports
____ Medications List

____ Progress Notes
____ Procedure Reports
____ EKG
____ Photographs, Videos, Digital or Other Images
____ Anesthesia Record
____ Diagnostic Imaging
____ Laboratory tests (please specify) _____
____ Other (please specify) _____

4. If applicable, I also give permission for the following to be disclosed (please initial)

____ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
____ Behavioral Health Services / Psychiatric Care
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_____ _____/_____/_____
Signed: (Patient, Legal Representative, Parent or Legal Guardian) (Date)

ID Provided _____

Official Use Only
Name of Person Releasing Information & Date of Release:
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