AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient _____	
Address _____	
Phone Number _____	**E-mail** _____
Birthdate _____	**Social Security Number** _____

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release (Check one)

☐ all health information about me ☐ my medical records as described on the following page:

Person/Organization to Release Information

Person/Organization Name: _____	
Phone Number: _____	**Fax Number:** _____

***We need 2 years of records only.

Person/Organization to Release Information To: Palm Coast Family Practice & Walk In Clinic _____		
Street Address 9 Pine Cone Drive, Suite 102 _____		
City Palm Coast _____	**State** FL _____	**Zip Code** 32137 _____
Phone Number 386-445-6191 _____	**Fax Number** 386-445-3916 _____	

The following health information that relates to service beginning from _____ [Date] to _____ [Date], may be released: (Check one)

☐ Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

☐ Only the following: (Check all that apply)

- ☐ Patient histories
- ☐ Office notes (except psychotherapy notes)
- ☐ Test results
- ☐ Radiology studies
- ☐ Films
- ☐ Other: _____
- ☐ Referrals
- ☐ Consults
- ☐ Billing records
- ☐ Insurance records
- ☐ Records sent by other health care provide

I further understand that my medical record may include one or more of the following: (Check all that apply)

- ☐ Treatment of communicable diseases, including STD's, tuberculosis, or hepatitis
- ☐ Treatment related to AIDS/HIV
- ☐ Mental health treatment or psychological conditions
- ☐ Alcohol or substance abuse treatment
- ☐ Genetic testing
- ☐ Other: _____

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of: (Check all that apply)

- ☐ Change of doctor
- ☐ Individual request
- ☐ Workers compensation
- ☐ Specialist referral
- ☐ Insurance purposes
- ☐ Continued treatment
- ☐ Legal investigation
- ☐ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for _____ (Check one) ☐ days ☐ months ☐ years following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient's Signature	**Patient's** Name	Date
Guardian or Legal Representative's Signature	**Guardian or Legal Representative's** Name	Date