

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

Name _____ Date of Birth _____ Social Security Number _____

INFORMATION TO BE RELEASED FROM: (Name of Facility or Provider)

Address: _____ Telephone: _____
_____ Fax number: _____

INFORMATION TO BE SENT TO:

Hunt Club Medical Care 3191 E. Semoran Blvd. Apopka, FL 32703 Tel 407-788-6500 Fax 407-869-9440
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INFORMATION TO BE RELEASED:

The most recent 2 years of pertinent information (chart notes, labs, radiology reports, and special tests)
 All medical records Immunization Records EKG, Cardiac studies
 Other: _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

Medical care Attorney Insurance Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

Drug/Alcohol abuse/treatment & diagnosis Sexually transmitted disease
 HIV/AIDS diagnosis/treatment/testing Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipients, that the person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

X _____
Signature (Patient, guardian, or Authorized representative) Date of Authorization

_____ _____
Print Name if not patient Witness

This authorization will expire 90 days from the date signed.