

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: ____/____/____

Address: _____

City/Street/Zip Code: _____

Patient's Phone: () _____ - _____

I authorize Flagler Family Medicine to
release my medical information to:

OR

I authorize Flagler Family Medicine to
obtain my health information from:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone# Fax# (include area code)

Phone# Fax# (include area code)

PURPOSE FOR THIS REQUEST: (check one)

Healthcare Personal Transfer of Care Other Explain: _____

TYPE OF RECORDS REQUESTED: (Check One)

All medical records related to a specific illness or injury.

Specify illness/injury _____ Date(s) of treatment _____

Treatment Summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

Immunization History

Specific information (Select one or more as applicable):

Procedure Report History & Physical Laboratory test results X-ray reports HIV/AIDS

Psychiatric/Psychological evaluations/treatments Drug and Alcohol Treatment Information

Other: _____

(Please describe)

Copy of entire medical record, as allowed by law.

AUTHORIZATION VALID FOR: (Check One)

This request only.

One year from the date of this authorization **OR** _____. (Insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

This request **AND** for medical records of any **future** treatment of the type described above until _____ (insert date)

I understand that:

- My right to healthcare treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a **written** request to the address below except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by federal privacy regulations, the information stated above could be re-disclosed.
- Authorization for Release of HIV/AIDS related information, mental health, or substance abuse diagnosis and treatment information will expire in **60 days**.
- There may be a charge for the request records.

Signature of Patient/Legal Representative _____ Date: _____

Printed Name of Signer: _____

Relationship to Patient: _____



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