AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____
Address: _____
City/State/Zip Code: _____
Patient's Phone: ( ) _____- _____

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

Name of Provider or Facility _____
Address _____
City, State, Zip Code _____
Phone# (include area code) _____
Fax# (include area code) _____

OR

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

Name of Provider or Facility _____
Address _____
City, State, Zip Code _____
Phone# (include area code) _____
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: _____

☐ 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:_____

FLAGLER FAMILY MEDICINE & WELLNESS

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