



Authorization to Obtain/Release of Medical Records

(This form applies only to release and/or disclosure of patient information. It is not a consent for treatment or intended for any purpose.)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Phone: \_\_\_\_\_

- Obtain records from Facility Release records to Facility Request copies of my Medical Records (personal use)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

- All records: Between dates of: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

-Or-

- For the following period \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ on the description below:

Information to be release/obtained:

- History & Physical ER/Urgent Care Lab Reports Discharge Summary X-Ray Reports Itemized Billing Statement Progress Note Diagnostic Test Reports Other (Specify content and dates): \_\_\_\_\_

Please be aware there is a fee of \$1.00 for the first 25 pages and an additional \$0.25 per page. Depending on your request, it can take up to 10 business days to receive records, though most request are fulfilled sooner. \_\_\_\_\_ INITIALS

By signing this form, I authorize DELTA INTERNAL MEDICINE CENTER to use, release or obtain protected health information described above:

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law (F.S 395.3025, F.S. 456.057 45CFR ss164.524). Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

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