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MEDICAL RELEASE FORM

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Please select your doctor: ☐ **Dr. S. Tracy Rhodes** ☐ **Dr. Lucille Belnick**

I, ____ Date of birth: _____/_____/_______, authorize the physician, office and or facility listed below to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician selected above.

Please release the following information contained in my protected medical records regarding my hospitalization, care and treatment:					
PLEASE LEAVE BLANK FOR OFFICE STAFF TO FILL WHEN NEEDED					
	Complete Medical Records		All Diagnostic Test Results		Pathology Reports
	Operative Reports		Radiology Reports		Lab Results
	Office Visit(s)		Therapy Records		Other: ______________________

More details: ____

____

Records to be faxed to 407-679-3412 from:	
PLEASE LEAVE BLANK FOR OFFICE STAFF TO FILL WHEN NEEDED	
Physician/Facility/Person	
Phone Number / Fax Number	Phone: __________________________ Fax: __________________________
Address	

Records released to not include:			
	HIV/AIDS		Mental Health
	Drug and/or Alcohol abuse		Genetic Counseling/Testing information

If I fail to specify an expiration event or condition, the authorization will expire within one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action had already been taken on this authorization. I understand that my protected health information that issued or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that I can request a signed copy of this form.

☐ **I give consent for this office to hold a hard copy of this records release to be held for one year of signed date and to only be used when a verbal consent is given to obtain records from a physician/facility/office.**

☐ **I do not give consent for this office to hold a hard copy of this records release and authorize this release to expire on the following date, event or condition: ____**

____ ________/________/___________
PATIENT/LEGAL REPRESENTATIVE OR PARENT/LEGAL GUARDIAN SIGNATURE TODAY'S DATE

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