MEDICAL RECORD RELEASE AUTHORIZATION

Name:______________________________ Florida Tech ID:_______________ Birth Date:_____________ Phone:____________

I give authorization for the use or disclosure of the above individual's health information as described below:

1) **Released from:** ☐ **Premier Urgent Care / Holzer Health Center** ☐ Other

Facility Name ____

Address ____State ________ Zip____________

Phone # ____________________________ Fax # ______________________________

Released to: ☐ **Premier Primary Care / Holzer Health Center** ☐ Other

Please check one ☐ Fax ☐ Pick up ☐ Mail ☐ E-Mail

Name ____

Address ____ City: ______________________ State ______ Zip________

Phone # _______________________________ Fax #: ____________________________

Email ______________________________________

Please Note: Email sent over the Internet or via fax are not necessarily secure. Florida Tech Holzer Health Center cannot guarantee the confidentiality or security of any information sent over the Internet when using email, or by fax. The Florida Tech Holzer Health Center shall not be liable for any breach of confidentiality resulting from such use of email.

2) Type of information to be used or disclosed (check one)
- ☐ All Medical Records (excluding vaccine records)
- ☐ Vaccine Records (Administered at Holzer Health Center Only)
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Work Comp
- ☐ Lab Results

3) Including any of the following related super confidential information (check one)
- ☐ HIV/AIDS
- ☐ Mental Health with MD psychiatrist, Dr. Stump
- ☐ Reportable STDs

4) Dates of service requested (check one)
- ☐ First year attended FIT ________________________
- ☐ Past 12 months
- ☐ The specific time period from ________________________ to ________________________

5) The information I am authorizing disclosure for will be used for the following purpose
- ☐ Continued Care
- ☐ My Personal Records
- ☐ Legal Purposes
- ☐ Other (please describe) ____

I understand that this authorization will remain in effect for six (6) months and that I have the right to revoke this authorization at any time in writing presented to the health information management facility where my information is maintained. I further understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that once the information described above is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal law or regulation. I understand authorizing the use or disclosure of the information described above is voluntary and I need not sign this form to ensure healthcare treatment. If I have any questions about the disclosure of my health information, I can contact the Medical Records Department where I have received treatment.

____ ______________________________

(Signature of Patient or Legal Guardian*) (Date)

* If legal representative, relationship to patient ____

---OFFICE USE ONLY---

☐ Request Complete Date:_________________ Initials:_____________ Comments:____________________________

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