Premier Urgent Care/Holzer Health Center at Florida Tech

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____DOB___/____/_____ID/SS# _____Ph#_____

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

Name _____

Address _____State _____Zip_____

Phone # _(____)_____ Fax # _(____)_____

Email _____

2) Type of information to be used or disclosed (check one)
□ All Medical Records (excluding vaccine records) □ Vaccine Records □ Progress Notes
□ Lab Results □ Radiology Reports □ Consultation Reports □ Work Comp

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 _____ Proof of Relationship _____

_____ _____
(Witness Receiving Request) (Date)

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