FLORIDACARE MEDICAL CENTER

Medical Records Release Authorization Form

Patient Information:

Patient's Full Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Release Information:

I, _____, authorize the release of my medical records from ***Florida Care Medical Center***

Name of Healthcare Provider: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Fax Number (if applicable): _____

To:

Name of Recipient (e.g., New Healthcare Provider, Individual): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____
Fax Number (if applicable): _____

Information to be Released:

[] All Medical Records

[] Specific Dates of Treatment: From _____ to _____

[] Specific Medical Information (Specify): _____

Purpose of Disclosure:

[] Continuity of Care

[] Personal Records

[] Legal Reasons (e.g., litigation)

[] Other (Specify): _____

Authorization and Signature:

I understand that the information released may include information relating to the diagnosis or treatment of HIV/AIDS, mental health, alcohol or drug abuse, or other sensitive medical information, and I specifically authorize the release of this information.

Patient's Signature: _____ Date: _____

Witness (If required):

Signature: _____ Date: _____

Printed Name: _____

HIPAA Privacy Act Acknowledgment:

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient's Signature: _____ Date: _____