PIÑERO PREVENTIVE MEDICAL CARE

Medical Records Release

Phone 407-426-9693 Fax 407-426-9694

Patient Name _____ **Date of Birth** _____

Previous Name _____ **Daytime Phone** _____

Please check one:

I request and authorize PPMC to: ☐ Release To ☐ Obtain From

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

You may use or disclose the following health care information (check all that apply):

Patients who request their records may be charged a $1.00 per page up to 25 pages and $.25 for each additional page. All payments are required prior to copying. All records sent electronically to another clinician for the continuation of care, will be at no cost.

☐ Chart Notes ☐ Most Recent Office Visit

☐ Labs / Pathology ☐ All Records

☐ X-rays /Diagnostics/EKG

☐ Immunizations

Reason for Authorization: ☐ At the request of the individual ☐ Continuity of Care

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized PPMC to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to PHMG, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months.

I understand that my health information to be released MAY INCLUDE information that is related to:
sexually transmitted disease
acquired immunodeficiency syndrome (AIDS)
human immunodeficiency virus (HIV)
behavioral or mental health services
and/or treatment for alcohol and/or drug abuse.
My signature below authorizes release of all such information, unless otherwise indicated.

_____ _____ _____

Signature/Legally Responsible Party Relationship to Patient Date