Patient Authorization for Release of Health Records to External Parties

I authorize

to disclose information from the health records of

DOB

Month Day Year

The information is to be disclosed to:

I authorize this information to be disclosed in the following ways:

- ☐ Written/Photocopy/Paper
- ☐ Electronic Format
- ☐ Verbal
- ☐ Fax
- ☐ Electronic Mail

Purpose of the disclosure:

Dates of Treatment From:

Month Day Year

To

Month Day Year

I give specific authorization to disclose the following information:

- ☐ HIV test results
- ☐ Documentation of AIDS diagnosis
- ☐ Drug and alcohol abuse treatment records
- ☐ Psychiatric/Mental Health treatment records

Specific reports to be disclosed:

- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ X-ray films or other images
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Photographs/Videotapes
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Records from other facilities
- ☐ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Florida Diabetes and Endocrine Associates LLC in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Florida privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time:

Hour Minutes

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Printed Name of Patient or Patient Representative

Authority of Representative to Act for Patient (Relationship to Patient)

Date

Month Day Year

7001 N DALE MABRY HWY, SUITE #2, TAMPA FL33614
PHONE : 813-252-9849 FAX : 813-569-2455