AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ **hereby authorizes the use or disclosure of the individually**

Print Patient/Legal Representative or Parent/Legal Guardian Name

identifiable health information of _____ **as described herein.**

Print Patient Name Date of Birth

Person/organization authorized to **use/disclose** the information:	Person/organization authorized to **receive** the information:
Name/organization _____	Name/organization _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

For the purpose of: ❑ Legal ❑ Moving Out of Area ❑ Changing Physicians ❑ Continuing Care

❑ Other (please specify) _____

Preferred Method of Receipt: ❑ Mail ❑ Fax ❑ Email: _____

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however, the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not a healthcare provider, plan or business associate (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

This authorization will expire on _____ (NOTE: If left blank, it will expire 12 months from date signed).

Date(s) of Service: From: _____ To: _____

Place your <u>INITIALS</u> by each item to be released or reviewed:

_____ Office Visits

_____ Diagnostic Test Results

_____ Lab Reports

_____ Pathology/Operative Report(s)

_____ Complete Record (charges may apply)

_____ Other (specify) _____

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In addition, place your <u>INITIALS</u> by each specific item: (if applicable)

_____ Mental Health _____ HIV Testing _____ Genetic Counseling/Testing Information

_____ Drug and/or Alcohol _____ AIDS Information _____ STD/Communicable Diseases

_____ _____

Patient/Legal Representative or Patient/Legal Guardian ***Signature Required*** Date of Authorization

_____ _____ _____

Patient Date of Birth Social Security Number (optional) Telephone Number

_____

Address City State Zip Code

Official Use Only: _____

Name of Person Releasing Information **Date**

Copying Costs:

The charge for copying costs for medical records is one dollar ($1.00) per page up to twenty-five (25) pages and twenty-five cents ($0.25) for each page thereafter. Please allow seven (7) to ten (10) business days for records to be copied.

Please mail, fax or email your completed medical records request form to one of our below locations. Please select the location that is closest to your home address.

8786 Perimeter Park Boulevard, Jacksonville, FL 32216	Fax (904)997-9205	Phone (904)997-9202
2639 Oak Street, Jacksonville, FL 32204	Fax (904)388-0114	Phone (904)387-5600
564 Health Boulevard, Daytona Beach, FL 32114	Fax (386)239-8984	Phone (386)258-5777
1025 Primera Boulevard, Lake Mary, FL 32746	Fax (407)333-1381	Phone (407)333-1570
95 Columbia Street, Orlando, FL 32806	Fax (407)420-4056	Phone (407)849-9621

To email your request, please complete this form in it's entirety, scan as an attachment and email to contact@floridaretinainstitute.com.

Thank you.