MEDICAL RECORD RELEASE AUTHORIZATION FORM

Patient Name: ______________________________________ Date of Birth: ___________________
Address: ____ Patient's Phone: _________________

- I, hereby authorize The Boca Grande Health Clinic to release my Protected Health Information to the following person(s)/organization(s):
  Name: ____
  Address: ____
  Phone: ________________________________ Fax: _________________________________

OR

- I, hereby authorize _________________________________ Fax:______________________ to release my Protected Health Information to:

  Name: Boca Grande Health Clinic, Inc.
  Address: PO Box 517, Boca Grande FL 33921
  Phone: 941-964-2276
  Fax: 941-964-2983

- <u>Information to be Disclosed:</u>
  - ☐ Entire Record
  - ☐ Lab Results
  - ☐ History and Physical Exam
  - ☐ X-ray Reports
  - ☐ Operative Records
  - ☐ Billing and Payment Information
  - ☐ Progress notes
  - ☐ Photographs, other images
  - ☐ Consult Reports
  - ☐ Genetic Test Results
  - ☐ Summary of Treatment
  - ☐ Other (specify) ___________________
- <u>Sensitive Information</u>: Please read carefully. By law you must sign below or we cannot release the following:
  - ☐ HIV/AIDS Test/Treatment
  - ☐ Sexually Transmitted Disease
  - ☐ Genetic Testing
  - ☐ Abortion
  - ☐ Mental Health Information
  - ☐ Drug/Alcohol Abuse
  - ☐ Sexual Assault

I understand that this authorization if voluntary. If I do not sign this form, my healthcare from Boca Grande Health Clinic, Inc. and the payment for this healthcare will not be affected

I understand that once my information is released, it may no longer be protected by federal privacy regulations.

I understand that I may see a copy of the information described on this form if I ask for it, and I will get a copy of this form after I sign it.

I understand that this authorization will expire: ______________________

I understand that after I have signed this form, I may change my mind and cancel this authorization at any time by notifying the Boca Grande Health Clinic Privacy Officer in writing. But if I do, it won't have any effect on actions Boca Grande Health Clinic, Inc. took before the revocation was received.

____ __________________
Signature of Patient/Representative Date

Relationship to Patient: ____________________________________