## MEDICAL RECORD RELEASE AUTHORIZATION FORM

Address:	Patient Name:			Date of Birth:		
Address: Phone:    Fax:		I, hereby authorize The Boca Grande Health Clinic to release my Protected Health Information following person(s)/organization(s):  Name:				
OR  I, hereby authorize						
OR  I, hereby authorize						
Name: Boca Grande Health Clinic, Inc. Address: PO Box 517, Boca Grande FL 33921 Phone: 941-964-2276 Fax: 941-964-2983  Information to be Disclosed:    Entire Record		Pnone:	Phone: Fax:			
Name: Boca Grande Health Clinic, Inc. Address: PO Box 517, Boca Grande FL 33921 Phone: 941-964-2276 Fax: 941-964-2983  O Information to be Disclosed:    Entire Record			$\mathbf{OR}$			
Name: Boca Grande Health Clinic, Inc. Address: PO Box 517, Boca Grande FL 33921 Phone: 941-964-2276 Fax: 941-964-2983    Information to be Disclosed:   Entire Record   Progress notes     Lab Results   Photographs, other images     History and Physical Exam   Consult Reports     X-ray Reports   Genetic Test Results     Operative Records   Summary of Treatment     Billing and Payment Information   Other (specify)     Sensitive Information: Please read carefully. By law you must sign below or we cannot release the following:   HIV/AIDS Test/Treatment   Mental Health Information     Sexually Transmitted Disease   Drug/Alcohol Abuse     Genetic Testing   Sexual Assault     Abortion     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 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:	0	I, hereby authorize		Fax:	_ to release	
Address: PO Box 517, Boca Grande FL 33921 Phone: 941-964-2276 Fax: 941-964-2983    Information to be Disclosed:		my Protected Health	h Information to:			
Phone: 941-964-2276 Fax: 941-964-2983  Information to be Disclosed:    Entire Record		Name: Boca Grande Health Clin		Clinic, Inc.		
• Information to be Disclosed:		Address: PO Box 517, Boca Grand		rande FL 33921		
o Information to be Disclosed:  □ Entire Record □ Lab Results □ Photographs, other images □ History and Physical Exam □ Consult Reports □ Genetic Test Results □ Operative Records □ Billing and Payment Information □ Other (specify) □ Sensitive Information: Please read carefully. By law you must sign below or we cannot release the following: □ HIV/AIDS Test/Treatment □ Sexually Transmitted Disease □ Genetic Testing □ Sexual Assault □ Abortion  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 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 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 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		Phone:	941-964-2276			
Entire Record		Fax:	941-964-2983			
Entire Record	0	Information to be D	pisclosed:			
Lab Results				☐ Progress notes		
History and Physical Exam		☐ Lab Results		☐ Photographs, other images		
X-ray Reports   Genetic Test Results   Operative Records   Summary of Treatment   Billing and Payment Information   Other (specify)		$\Box$ History and	Physical Exam			
Operative Records						
Billing and Payment Information				☐ Summary of Treatment		
Sensitive Information: Please read carefully. By law you must sign below or we cannot release the following:  ☐ HIV/AIDS Test/Treatment ☐ Mental Health Information ☐ Sexually Transmitted Disease ☐ Drug/Alcohol Abuse ☐ Genetic Testing ☐ Sexual Assault ☐ Abortion  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 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						
HIV/AIDS Test/Treatment   Mental Health Information   Drug/Alcohol Abuse   Genetic Testing   Sexual Assault   Sexual Assault	0	Sensitive Information	<del>-</del>	· · · · · · · · · · · · · · · · · · ·	ise the	
Genetic Testing □ 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: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		•		_		
Genetic Testing 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		<del></del>				
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:				<u> </u>		
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			ting	☐ Sexual Assault		
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:		☐ Abortion				
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			•	, ,	Grande	
of this form after I sign it.  I understand that this authorization will expire:	I unde	rstand that once my i	nformation is released, i	t may no longer be protected by federal privacy r	egulations	
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		•	a copy of the informatio	on described on this form if I ask for it, and I will	get a copy	
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	I unde	rstand that this autho	rization will expire:			
	by not	ifying the Boca Gran	de Health Clinic Privacy	Officer in writing. But if I do, it won't have any		
Relationship to Patient:	Signature of Patient/Representative			Date		
	Relatio	onship to Patient:				