Physicians' Primary Care OF SOUTHWEST FLORIDA

Adult Medicine Division

Authorization for Release of Medical Record Information

Patient's Legal Name: _____ **Date of Birth:** _____

I Authorize the Following Provider to Release my Protected Health Information:

Name: _____

Address: _____

_____

Telephone: _____ Fax:_____

Information Released to:

Name: _____

Address: _____

_____

Telephone: _____ Fax:_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Information to be Disclosed: - **Last two years of records will be provided unless otherwise noted below

☐ Office Notes _____ ☐ Diagnostic Reports _____

☐ Laboratory Reports_____ ☐ Last two years of Health Record _____

☐ Colonoscopy Report_____ ☐ Pathology Report_____

☐ Immunization Record_____ ☐ Other _____

Reason for Disclosure:

☐ Continuation of Treatment ☐ Legal ☐ Insurance ☐ Payment ☐ Personal ☐ Other

Are you leaving the practice? ☐ Yes ☐ No

I understand that this authorization will **NOT** include the following information unless indicated and initialed below:

_____ AIDS or HIV Infection _____ Sexually Transmitted Disease Information

_____ Behavioral Health Care/Mental Health Services _____ Treatment for alcohol and/or drug abuse

As described in the Notice of Privacy Practices of Physicians' Primary Care of Southwest Florida, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians' Primary Care of Southwest Florida in reliance on this authorization, by sending a written revocation to Physicians' Primary Care of Southwest Florida, 12730 NEW BRITTANY BLVD. SUITE 602, FORT MYERS, FL 33907, ATTN: Privacy Officer

Physicians' Primary Care of SWFL has partnered with HealthMark Group to ensure the accurate and timely completion of medical records requests.

I understand that this authorization is valid for up to six months from the date I sign it unless I specify otherwise. **Further, I understand that I will not be denied or refused treatment if I refuse to sign this authorization.**

_____ _____ _____

Signature of Patient or Legal Representative **Date** **Relationship to Patient**