255 SE 17th St
Ocala, FL 34471
Phone: (352) 509-6446
Fax: (877) 583-4671

Authorization for Medical Records Release

Patient Name (First and Last): _____ Date of Birth: _____

I hereby authorize and request _____ to release medical information concerning my medical care to Above All Medical Clinic and affiliates for the purpose of:

_____

(Specific purpose for disclosure of record)

____ All Records
____ Bone Density
____ Eye Exam
____ Last 3 Progress Notes
____ Most Recent Laboratory Test Results
____ Most Recent Diagnostic Test Results
____ Most Recent X-Ray Report
____ Problem List/Medications List
____ Other

I understand that the information released may include information concerning HIV testing or treatment of AIDS and/or AIDS related conditions, drug and/or alcohol abuse (or related conditions), and mental health concerns.

I understand that the use and/or disclosure of my individual health information as described above and that this authorization will expire, without my express revocation, either one (1) year from the date of signing or, if I am a minor, on the date I become an adult, according to the state law, whichever occurs first.

I understand that authorization for the disclosure of this health information is voluntary, I can refuse to sign this authorization, and that this authorization is revokable upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation and that it may be re-disclosed by the recipient.

The facility, its employees, officers, Advanced Practice providers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.

_____ _____

Patient/Guardian Signature Date