Authorization for Disclosure of Medical Record Information

1715 37TH PLACE, 2ND FLOOR, VERO BEACH, FL 32960

Phone: 727-794-2222 Fax: 727-794-0045

I, the undersigned, authorize **INDIAN RIVER PRIMARY CARE** to release my health information as noted below:

Patient Information

Patient Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Release Information To

I hereby authorize doctor ☐ DR. DALILI ☐ DR. LEWIS ☐ DR. Arnold of **Indian River Primary Care** to receive my medical record information by the following methods:

☐ Mail ☐ Fax ☐ Electronic Copies to: **OR** ☐ Discuss Medical Information With:

Sending Facility

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○ Personal ○ Continuing Care ○ Legal ○ Insurance ○ Other _____

Information to be released

Comments

- ○ **MEDICAL HISTORY & NOTES**
- ○ **RADIOLOGY & PATHOLOGY**
- ○ **LABS**
- ○ **CONSULTS**
- ○ **OTHER** - please be specific, include dates and MD's under

Authorization to Release Protected Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one *Initial each line below to confirm your choices*

I ☐ **DO** ☐ **DO NOT** want ***Psychiatric Treatment Notes** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

I ☐ **DO** ☐ **DO NOT** want information about _____ released _____

Other sensitive information?

STOP Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected infomation is not released, we may be unable to fulfill this request.

Sign Here **Date Here**

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature** **Date****

Witness **Date**

Know Your Privacy Rights
Refer to the
HIPAA "PRIVACY NOTICE"

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise:_____. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that Indian River Primary Care has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection law.