centrum HEALTH

Reset Form

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. **PATIENT INFORMATION:**

Full Name _____ Date of Birth _____

Street Address (include city, state, and zip code) _____

Email Address _____ Phone Number _____

2. **RELEASE MEDICAL RECORDS OF THE PATIENT ABOVE TO THE FOLLOWING INDIVIDUAL OR ENTITY (you may write to "myself"):**

Name _____ Phone Number _____

Street Address _____ City/State/Zip Code _____

Email Address _____ Fax Number _____

Attention _____ Other necessary contact information _____

3. **DATES OF SERVICE REQUESTED: (From)** _____ To _____

4. **Delivery Method: (to the information provided in Section 2)**

☐ **Mail** ☐ **Email** ☐ **Other (Please specify)** _____

5. **MEDICALRECORDS TO BE RELEASED:** (REQUIRED - Check Items Below)

☐ Office Visits- i.e. progress notes, medication list, medical history ☐ Echoes- i.e. cardiology

☐ Laboratory Reports- i.e. bloodwork, cultures ☐ Referral-specialists ☐ Billing Records

☐ Radiology Reports- i.e. x-rays ☐ Other (please specify): _____

6. **Disclosure of Sensitive Information: I give specific consent to release my medical records that relate to the following areas:**

☐ HIV Test Results

☐ Substance Abuse

☐ Mental Health Records: If you are requesting a copy of your mental health records with this form, Florida allows such access, unless such access is determined by your physician to be harmful to you. For more information, see Florida Statute 394.4615(10)

☐ **ALL RECORDS (including all Sensitive Information) Initials here:** _____

7. **PURPOSE OF RELEASE:** (REQUIRED)

☐ Personal Copy ☐ Disability Determination ☐ Insurance Purposes ☐ Legal Matter

☐ Transfer of Care (Specify Reason): _____ ☐ Other (Please explain) _____

8. **SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IFPATIENT IS 18 YEARS OR OLDER):**

I acknowledge I am the patient, a legal representative, or an authorized person of the patient listed above. By signing below, I am authorizing **Centrum Medical Holdings, LLC, doing business as Centrum Health, and its affiliates** the release and disclosure of the patient's protected health information. This authorization is valid for 12 months from the date of signature. I understand that I have the right to revoke this authorization and withdraw my permission with written notification, and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that Centrum Health to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

Signature of Legal Representative/Patient 18yrs or older _____ Date _____

Print Name of Legal Representative/Patient 18yrs or older _____ Relationship to Patient _____

Submit Form