AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

Name	Date of Birth	Social Security Number
______________________________	__________	________________

INFORMATION TO BE RELEASED FROM: (Name of Facility or Provider)

____

Address: ______________________________ Telephone: ________________

______________________________ Fax number: ________________

INFORMATION TO BE SENT TO:

Hunt Club Medical Care
3191 E. Semoran Blvd.
Apopka, FL 32703
Tel 407-788-6500 Fax 407-869-9440

INFORMATION TO BE RELEASED:

___ The most recent 2 years of pertinent information (chart notes, labs, radiology reports, and special tests)

___ All medical records ___ Immunization Records ___ EKG, Cardiac studies

___ Other: ____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

____ Medical care ____ Attorney ____ Insurance ____ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

____ Drug/Alcohol abuse/treatment & diagnosis ____ Sexually transmitted disease

____ HIV/AIDS diagnosis/treatment/testing ____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipients, that the person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

X______________________________ ______________________________

Signature (Patient, guardian, or Authorized representative) Date of Authorization

______________________________ ______________________________

Print Name if not patient Witness

This authorization will expire 90 days from the date signed.