AdventHealth
Centra Care

AUTHORIZATION RELEASE OF MEDICAL RECORDS (PROTECTED HEALTH INFO)

I,_____, hereby

authorize the release of my medical records dated: __/__/20__ to __/__/ 20__ .

☐ Picked up by _____ (Photo ID Required)

☐ Mailed to:

_____

Self, Physician, Hospital Name, etc… Phone

_____

Address City State Zip

☐ Fax: ***We will only fax records to a health care provider (Hospital, insurance company, or doctors office)***

_____

Company / Name Phone Fax

I UNDERSTAND THAT THE SPECIFIC REPORTS DISCLOSED SHALL INCLUDE:

☐ All records

☐ Records specific to: _____
Please specify: R/L, leg, arm, wrist, shoulder, back, etc…

THE SPACES BELOW GIVE SPECIAL AUTHORIZATION FOR THE RELEASE OF SUPER CONFIDENTIAL INFORMATION REGARDING ALCOHOLISM AND/OR DRUG ABUSE, HIV (AIDS) TESTING, AND/OR TESTING FOR SEXUALLY TRANSMITTED DISEASES

INITIAL EACH LINE THAT APPLIES

_____ Medical information regarding alcoholism and/or drug abuse (if applicable) may be Released to the recipient noted above.

_____ Medical information regarding HIV (AIDS) testing and/or testing for sexually Transmitted diseases (if applicable) may be released to the recipient above.

_____ Medical information regarding psychiatric care/or counseling (if applicable) may be released to the recipient above.

I Understand:

1. **This consent is revocable by me, in writing any time except after the action has taken place.**
2. **This consent will expire either in one year after the date of signature or automatically when the records requested on this form have been mailed to the above requested.**
3. **The medical records provided in response to this request are subject to further distribution in relation to workplace injury if applicable.**
4. **That I may refuse to sign this authorization.**

Date:_____Signed:_____SS#/DOB_____
PATIENT

ID Verified: _____

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REV 11/2015