Authorization to Disclose Health Information

I, the undersigned, authorize

FL465: FAMILY HEALTH CENTER OF GREATER ORLANDO

2911 Red Bug Lake Road Casselberry, FL 32707

Patient Information:

to release my health information as noted below:

Patient Full Name: _____ Email address: _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To:

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Charges outlined below will be applied for all copies released directly to patient . The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released:

Unless otherwise specified, only the following information will be released:
Medical History, Progess Notes, Lab Reports , Diagnostic Testing, and Surgical Reports.

☐ **Please provide a 2 year Abstract of my records**

Patient Directive Fees apply and are calculated according to delivery method and average costs.

☐ **Other (Please be specific)**

Comments: _____
_____
_____

~~PAYMENT OPTIONS:~~
No charge for records released prior to May 31, 2017

CHECK: Please make checks available to BACTES Imaging Solutions.

CREDIT CARD: Please provide an email address to have an invoice sent. If you do not have an email address, an invoice will be sent to your mailing address .

☐ Check here if you would like your records sent electronically

EMAIL ADDRESS:_____

Authorization to Release Protected:

***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.

Check one		*Initial each line below*
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?"	

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 information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____**Date:**_____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying Family Health Center of Greater Orlando in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Family Healthcare Center of Greater Orlando and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*