Physicians' Primary Care

Authorization for Release of Medical Record Information:

Patient's Legal Name: _____ Date of Birth:_____

I Authorize the Following Provider to Release my Protected Health Information:

Name:_____

Address:_____

_____

Telephone: _____ Fax: _____

Information to be released to:

Name: _____

Address:_____

_____

Telephone:_____ Fax:_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Information to be disclosed (please include dates where applicable):

❒ Office Notes_____ ❒ Diagnostic Reports_____

❒ Laboratory Reports_____ ❒ Complete Health Record_____

❒ Specific Conditions _____ ❒ Other_____

Reason for disclosure:

❒ Continuation of Treatment ❒ Legal or Insurance ❒ Payment ❒ Personal ❒ Other

Are you leaving the practice? ❒ Yes ❒ No

I understand that this authorization will **NOT** include the following information unless indicated and initialed below:

____AIDS or HIV Infection ____Sexually Transmitted Disease Information

____Behavioral Health Care/Mental Health Services ____Treatment for alcohol and/or drug abuse

As described in the Notice of Privacy Practices of Physicians' Primary Care of Southwest Florida, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians' Primary Care of Southwest Florida in reliance on this authorization, by sending a written revocation to Physicians' Primary Care of Southwest Florida, 13710 Cypress Terrace Circle, Fort Myers, FL 33907, ATTENTION: Privacy Officer

I understand that this authorization is valid for up to six months from the date I sign it unless I specify otherwise. I also understand that I may be charged for copies of my medical records as allowable under Florida Administrative Code Rule: 64B8-10.003. **Further, I understand that I will not be denied or refused treatment if I refuse to sign this authorization.**

_____ _____ _____

Signature of Patient or Legal Representative Date Relationship to Patient

1261 Viscaya Parkway, Suite 101
Cape Coral, Florida 33990
239.573.7337
Fax- 239.574.5883

9350 Camelot Drive
Fort Myers, Florida 33919
239.481.5437
Fax- 239.481.0570

5700 Lee Blvd
Lehigh Acres, Florida 33971
239.481.5437
Fax- 239.481.0570

Physicians' Primary Care OF SOUTHWEST FLORIDA