Physicians' Primary Care OF SOUTHWEST FLORIDA

Adult Medicine Division

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 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 – **Last two years of records will be provided unless otherwise noted below

❒ Office Notes_____ ❒ Diagnostic Reports_____

❒ Laboratory Reports_____ ❒ Last two years of Health Record_____

❒ Colonoscopy Report_____ ❒ Pathology Report_____

❒ Immunization Record_____ ❒ 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, 12730 NEW BRITTANY BLVD, SUITE 602, 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

1255 Viscaya Parkway, Suite 200
☐ **Cape Coral, Florida 33990**
239.574.1988
Fax – 239.574.1435

5700 Lee Boulevard
☐ **Lehigh Acres, Florida 33971**
239.482.1010
Fax – 239.481.1481

7381 College Parkway, Suite 110
☐ **Fort Myers, Florida 33907**
239.482.1010
Fax: 239.481.1481

1708 Cape Coral Parkway, Suite 4
☐ **Cape Coral, FL 33914**
239.945.5940
Fax – 239.945.5941

1304 SE 8th Terrace
☐ **Cape Coral, FL 33990**
239.574.1988
Fax – 239.574.7765

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