



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 Insurance Legal 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 Pkwy West, Ste 4 Cape Coral, FL 33914 239.574.1988 Fax - 239.574.7765

1304 SE 8th Terrace Cape Coral, FL 33990 239.574.1988 Fax - 239.574.7765