Premier Urgent Care
Badolato Family Health at Suntree / Viera

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ___________________________________ DOB___/____/____SS# _________________Ph#________________
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I give authorization for the use or disclosure of the above individual's health information as described below:

1) **Released from:** ☐ **Premier Urgent Care/Badolato Family Health** ☐ Other

Facility Name ____

Address ____State ________Zip____________

Phone # _(_____)________________________ Fax # _(____)______________________

Released to: ☐ **Premier Urgent Care/Badolato Family Health** ☐ Other

Name ____

Address ____State ______Zip______________

Phone # _(____)__________________________ Fax # _(____)________________________

2) Type of information to be used or disclosed (check all that apply)
☐ All Medical Record types ☐ History & Physical ☐ Progress Notes ☐ Auto
☐ Lab Results ☐ Radiology Reports ☐ Consultation Reports ☐ Work Comp
☐ Other ____

3) Including any of the following related super confidential information (check all that may apply)
☐ HIV/AIDS ☐ Mental Health ☐ Substance Abuse Treatment ☐ Reportable STDs

4) Dates of service requested (check one)
☐ All Medical Records
☐ Past 12 months
☐ The specific time period from ________________________ to ________________________

5) The information I am authorizing disclosure for will be used for the following purpose
☐ Continued Care ☐ My Personal Records ☐ Legal Purposes
☐ Other please describe) ____

I understand that this authorization will remain in effect for six (6) months and that I have the right to revoke this authorization at any time in writing presented to the health information management facility where my information is maintained. I further understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that once the information described above is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal law or regulation. I understand authorizing the use or disclosure of the information described above is voluntary and I need not sign this form to ensure healthcare treatment. If I have any questions about the disclosure of my health information, I can contact the Medical Records Department where I have received treatment.

____ ______________________________
(Signature of Patient or Legal Guardian*) (Date)

* If legal representative, relationship to patient _____________________ Proof of Relationship ______________________

____ __________________________
(Witness Receiving Request) (Date)

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