

Premier Urgent Care Badolato Family Health at Suntree / Viera

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB ___/___/___ SS# _____ Ph# _____

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)

- | | | | |
|---|---|---|------------------------------------|
| <input type="checkbox"/> All Medical Record types | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Auto |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Work Comp |
| <input type="checkbox"/> 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)