



AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ hereby authorizes the use or disclosure of the individually
 Print Patient/Legal Representative or Parent/Legal Guardian Name
identifiable health information of _____ **as described herein.**

Print Patient Name

Date of Birth

Person/organization authorized to use/disclose the information: Name/organization _____ Address _____ City, State, Zip _____ Phone _____ Fax _____	Person/organization authorized to receive the information: Name/organization _____ Address _____ City, State, Zip _____ Phone _____ Fax _____
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For the purpose of: Legal Moving Out of Area Changing Physicians Continuing Care
 Other (please specify) _____

Preferred Method of Receipt: Mail Fax Email: _____

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however, the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not a healthcare provider, plan or business associate (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

This authorization will expire on _____ **(NOTE: If left blank, it will expire 12 months from date signed).**

Date(s) of Service: From: _____ **To:** _____

Place your INITIALS by each item to be released or reviewed:

- | | |
|---|-------------------------------------|
| _____ Office Visits | _____ Diagnostic Test Results |
| _____ Lab Reports | _____ Pathology/Operative Report(s) |
| _____ Complete Record (charges may apply) | _____ Other (specify) _____ |



In addition, place your **INITIALS** by each specific item: (if applicable)

_____ Mental Health _____ HIV Testing _____ Genetic Counseling/Testing Information
_____ Drug and/or Alcohol _____ AIDS Information _____ STD/Communicable Diseases

Patient/Legal Representative or Patient/Legal Guardian *Signature Required* _____ Date of Authorization

Patient Date of Birth _____ Social Security Number (optional) _____ Telephone Number

Address _____ City _____ State _____ Zip Code

Official Use Only: _____ Name of Person Releasing Information Date
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Copying Costs:

The charge for copying costs for medical records is one dollar (\$1.00) per page up to twenty-five (25) pages and twenty-five cents (\$.25) for each page thereafter. Please allow seven (7) to ten (10) business days for records to be copied.

Please mail, fax or email your completed medical records request form to one of our below locations. Please select the location that is closest to your home address.

- | | | |
|---|-------------------|---------------------|
| 8786 Perimeter Park Boulevard, Jacksonville, FL 32216 | Fax (904)997-9205 | Phone (904)997-9202 |
| 2639 Oak Street, Jacksonville, FL 32204 | Fax (904)388-0114 | Phone (904)387-5600 |
| 564 Health Boulevard, Daytona Beach, FL 32114 | Fax (386)239-8984 | Phone (386)258-5777 |
| 1025 Primera Boulevard, Lake Mary, FL 32746 | Fax (407)333-1381 | Phone (407)333-1570 |
| 95 Columbia Street, Orlando, FL 32806 | Fax (407)420-4056 | Phone (407)849-9621 |

To email your request, please complete this form in it's entirety, scan as an attachment and email to contact@floridaretinainstitute.com.

Thank you.