

Carson Family Care Center
1259 S. Pinellas Ave. Tarpon Springs, FL 34689
Phone: (727) 938-1908 Fax: (727) 938-8693

Authorization to Release Medical Records

Name _____ Date of Birth _____ SS# _____

Information to be Released From:

Name of facility or provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be Sent To:

Name of designated recipient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be Released (Check One):

- The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
 All medical records
 Specific information (please specify): _____

Purpose for Which the Disclosure is Being Made (Check One):

Attorney Insurance Doctor Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

Drug/Alcohol abuse/treatment & diagnosis Sexually transmitted disease
 HIV/AIDS diagnosis/treatment/testing Mental illness or psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
Patient, guardian, or authorized representative

Witness: _____