Medical Records Release Form

Patient's Name: _____ DOB: _____ Last 4 of SS#: _____

Address: _____ Phone: _____

I request and authorize: (YOUR DOCTOR'S INFORMATION GOES HERE)

_____

To release healthcare information of the patient named above to:

The Annex Healthcare 133 E Church Ave Longwood, FL 32750 844-THE-ANNEX (844-843-2663)

PLEASE FAX TO: 407-906-2632

This request and authorization applies to:

- ☑ Professional Opinion
- ☐ Full medical records held by this office.
- ☐ The most recent office visit
- ☑ A specific portion/section of the record as follows: List of Diagnoses/Current Conditions
- ☐ Radiology reports
- ☐ Medical record for the period _____ through_____
- ☐ Other diagnostic studies: _____

Purpose of the requested disclosure:

- ☑ At patient's request
- ☑ Continuing Care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon the authorization. I understand that I do not have to sign the authorization and that may not condition treatment on whether I sign this authorization. I further understand that if the person (s) or organization (s) authorized to receive the information is not a health plan or health care provider, the release information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize faxing of any information, I realize there are inherent risks in faxing Protected Health Information released to anyone other than health care provider. I understand I will get a copy of this form after I sign it.

PATIENT'S OR REPRESENTATIVE'S SIGNATURE: _____

DATE SIGNED: _____