Apollo Healthcare Associates LLC
Authorization to Release Protected Health Information

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street City State Zip

Date of Request: _____ Patient Phone: _____

I am requesting Apollo Healthcare Associates LLC:

☐ **Disclose/Release to:** ☐**Obtain my health information/medical record from:**

Name: _____

Address: _____

Street City State Zip

Phone: _____ Fax: _____

The type of information to be used or disclosed is as follows:
(Check the appropriate boxes and add other information where indicated)

☐ Entire Medical Record	☐ History & Physical	☐ ED Record
☐ Discharge Summary	☐ Operative Reports	☐ Radiology Images
☐ Radiology Reports	☐ Pathology Reports	☐ Laboratory
☐ Progress Notes	☐ Physician Orders	
☐ Office/Clinic Notes	☐ Office/Clinic Lab	

Service Dates Requested: _____

☐ Records to be mailed

☐ Records to be picked up by patient or designated person:
Name of designated: _____
(photo ID required)

This information for which I am authorizing disclosure will be used for the following purpose(s):

☐ Personal Records ☐ Legal Purposes ☐Insurance ☐Continued Care

☐ Other (specify): _____

Authorization to Release Protected Health Information

Authorization:

I authorize Apollo Healthcare Associates LLC (AHA) to make the disclosure as specified above.

I understand the health record may include information relating to Sexually Transmitted Diseases (STDs), Acquired Immune-Deficiency Syndrome (AIDS) or Human Immune-Deficiency Virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse. If I do not want these items released, I will indicate that on this form.

I understand I can cancel or revoke this authorization in writing to AHA. I understand actions already taken based upon this form cannot be revoked. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand unless revoked, this authorization will expire six months from the date it was signed or the date as specified by me:_____ (Date)

I understand once the above information is disclosed, it may be re-disclosed by the recipient and is no longer protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

If I have questions about disclosure of my health information, I can contact Apollo Healthcare Associates at the location listed below.

☐ I am the patient and understand and agree to the provisions of this authorization.

☐ I understand and agree to the provisions of this authorization as the patient's legal representative.

_____	_____	_____
Name of Patient	**Signature of Patient**	**Date**
_____	_____	_____
Name of Authorized Representative	**Signature of Authorized Representative**	**Date**

_____ **(Relationship to Patient)**

Apollo Healthcare Associates LLC
1326 Malabar Rd. SE
Suite 3
Palm Bay, FL 32907
P: 321-409-6100
F: 321-409-6063