ALLIANCE FAMILY PHYSICIANS, PA

4611 NW 53RD AVE

GAINESVILLE, FL 32653

PHONE: (352) 371-0301

1. Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden/Former Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Cell/Work/Other: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

1. I, Authorize my previous physician(s): please include the first and last name, city, state and phone or fax number if possible

Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: ( )\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Fax: ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: ( )\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Fax: ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: ( )\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Fax: ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

1. To release to: **Alliance Family Physicians, PA** by: Mail: **4611 NW 53rd AVE GAINESVILLE, FL 32653**

Fax: **(877) 298-6307** - **LESS THAN 50 PAGES ONLY !!**

Fax: **(352) 371-4635 – OVER 50 PAGES !!!!**

4. Information to be released: \_\_\_\_ All Records \_\_\_\_ Laboratory Reports \_\_\_\_ EKG Reports \_\_\_\_ Pathology Reports

\_\_\_\_ Last 3 Years \_\_\_\_ Radiology Reports \_\_\_\_ Immunizations \_\_\_\_ Operative Notes

\_\_\_\_ Medication List \_\_\_\_ History & Physical \_\_\_\_ Progress Notes \_\_\_\_ Hospital Reports

5. I also authorize the release of information pertaining to: \_\_\_\_ AIDS or HIV \_\_\_\_ Chemical Dependency \_\_\_\_ Mental health

1. Purpose of information disclosure: \_\_\_\_ Leaving Practice \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. This authorization shall be in effect for 12 months following the date of my signature.
2. I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand the Chemical Dependency clients/patients records are protected by Federal Law (42CFR Part2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.
3. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
4. A photocopy is as valid as the original document.
5. **I understand that all requests for information require 7-14 business days to process and complete.**
6. Signature of Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Please note that this request is not valid unless it is signed by the Patient/Guardian and dated)***