
Dr. Christina Rigas
10707 66th St N, Suite B
Pinellas Park, FL 33782
(727) 500-5161
Fax: (727) 575-7275

## REQUEST FOR RECORDS/PHI FOR CONTINUING CARE

TO PATIENT: PLEASE SEND SIGNED/COMPLETED FORM TO YOUR OTHER HEALTHCARE PROVIDERS

**Patient's Name:** _____ **DOB:** _____
**Address:** _____ **Suite:** _____
**City:** _____ **State:** _____ **Zip Code:** _____

**For continuity of care please release records as request below**

**RELEASE FROM:** _____

**Address:** _____ **Suite:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**Phone:** _____ **Fax:** _____

I request and authorize you to release any information which you may have relating to treatments and examinations, including substance abuse, mental health, or communicable diseases, which may be contained in my medical record (e.g. HIV, TB, STD), for the purposes of treatment, payment, and/or healthcare operations.

**RELEASE TO:** **Dr. Christina Rigas** Rest Assured Pulmonology Inc

10707 66th St N, Suite B, Pinellas Park, FL 33782 Fax: (727) 575-7275

**Specific information to be released:** _____

_____

I acknowledge that I have the right to revoke this authorization in writing to the extent that a covered entity has not already relied upon the patients' consent to disclose the PHI. This authorization remains in force until revoked. I understand the PHI disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rules. I understand that there may be a fee for the costs of copying/mailing associated with this request.

**Signature:** _____ **Date:** _____

If signed by other than patient, relationship to patient and authority:

Relationship/Authority: _____ Name: _____

This request is an exchange of health information between healthcare providers for treatment, payment, or healthcare operations, therefore, a HIPAA compliant release is not required (HIPAA 164.506).