Authorization of Release of Information/ Medical Records

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Patient Name: _____ Date:_____

Date of Birth:_____ S.S # _____

PATIENT WAITING TO SEE DOCTOR.

PLEASE SEND REQUEST RECORDS AS SOON AS POSSIBLE. THANK YOU.

PLEASE SEND INFORMATION/RECORDS BY: FAX

Please release the following information/ records

____ Prescription Profile
____ Doctor Progress Notes
____ Reports of Hospitalization
____ Diagnostic Reports (X-Rays, EKGs, CT Scans, MRIs, Bone Density, Lab Reports, etc.)

This information, including diagnosis and records of any examination or treatment rendered to me, is to include any Federal and State protected information under F.S. 394.459(9) Psychiatric information, F.S. 397.053 & 396.112 Drug and Alcohol Abuse information, and FD.S 381.609(2) Human Immunodeficiency Virus (AIDS and related Conditions).
I understand by approving the release of information in form of a fax, confidentiality cannot be assured, and I accept the risk that confidentiality maybe breached when faxing information.

I understand that this authorization shall expire (90) days from the date of my signature below. I hereby release DeYard Wellness Center and its employees from any liability that may arise from this release of information.

This release is necessary for appropriate evaluation for treatment by the above medical provider and this release is executed without coercion. I understand that the purpose of this authorization is to confirm medical history necessary to provide appropriate medical care, and if I refuse to sign this authorization, you reserve the right to deny medical care.

I understand that I may revoke this authorization at any time by notifying you in writing, except to the extent that you have already acted in reliance on this authorization.

Location of Records:

Name of Clinic, Doctor, Pharmacy or Imaging Center:_____

Address:_____

City:_____ State:_____ Zip: _____

Phone#_____ Fax#_____

Patient Signature: _____ Date:_____