John Ness, MD, PA.
Dr. Ness Family Practice
616 Universal Drive, Tallahassee, FL 32303
Office 850-385-1839 | *Fax* 850-386-8371

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) OR MEDICAL RECORDS

PATIENT NAME: _____
LAST FIRST MIDDLE (MAIDEN)

DATE OF BIRTH: _____ SSN: _____

PHONE # _____

Physician to RELEASE information:	**Physician to RECEIVE information:**
NAME:	NAME:
OFFICE #	OFFICE #
FAX #	FAX #
ADDRESS:	ADDRESS:
CITY:	CITY:
STATE / ZIP CODE:	STATE / ZIP CODE:

Specific Information to be Released:

- ☐ Immunization record, current year medical record (s), current one year of laboratory test results, and all X-ray and diagnostic study results.
- ☐ Immunization Records
- ☐ Only Records Listed: _____

Circle One: **&** **Initial Each Line:**

- ☐ **I DO / DO NOT** authorize release of records pertaining to testing or treatment of HIV/AIDS_____.
- ☐ **I DO / DO NOT** authorize release of records pertaining to mental health evaluation or treatment_____.
- ☐ **I DO / DO NO**T authorize release of records pertaining to treatment of drug or alcohol related issues_____.

When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of the information identified above is voluntary and is not required to ensure health care treatment. I have read and understood the nature of this authorization and understand that it may be revoked upon my written request to the office who is authorized to release information, except to the extent that this authorization has been acted upon prior to revocation. The person or physician I have authorized to release records has my permission to obtain, inspect, and reproduce my records and are relieved of any responsibility or liability that may arise from the release or reproduction of these records. Unless otherwise specified, this authorization will expire ninety (90) days from the date it is signed.

SIGNATURE OF PATIENT / GUARDIAN DATE

RELATIONSHIP TO PATIENT: DATE:

WITNESS (PRINT & SIGN) DATE