DAWSON INTEGRATIVE MEDICAL CENTER, LLC

Authorization to Obtain/Release of Medical Records

Patient Name: _____ **Date of Birth:** _____

Home Address: _____ **Telephone Phone:** _____

☐ **Obtain records** from Facility ☐ **Release records** to Facility ☐ **Request copies** of my Medical Records *(personal use)*

Name: _____

Address: _____

Phone: _____

Fax: _____

☐ All records: Between dates of: ____ / ____ /_____ to ____ / ____ /_____

-Or-

☐ For the following period ____ / ____ /_____ to ____ / ____ /_____ on the description below:

Information to be release/obtained:

☐ History & Physical ☐ ER/Urgent Care ☐ Lab Reports

☐ Discharge Summary ☐ X-Ray Reports ☐ Itemized Billing Statement

☐ Progress Note ☐ Diagnostic Test Reports

☐ Other (Specify content and dates): _____

Please be aware there is a fee of $1.00 for the first 25 pages and an additional $0.25 per page. Depending on your request, it can take up to 10 business days to receive records, though most request are fulfilled sooner. _____ INITIALS

By signing this form, I authorize DAWSON INTEGRATIVE MEDICAL CENTER, LLC to use, release or obtain protected health information described above:

I understand that my records are confidential and cannot be disclosed without my written authorization, expect when otherwise permitted by law (F.S 395.3025, F.S. 456.057 45CFR ss164.524). Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature _____ **Relationship** _____ **Date** _____

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