MEDICAL RECORD RELEASE

URGENT REQUEST YES NO

Date Needed by: ____________

PRACTICE LOCATION
17912 Toledo Blade Blvd
Suite A
Port Charlotte, FL 33948
tele: 941.875.9059
fax: 941.206.2066

1) **PATIENT INFORMATION:**

Name ______ Address ______ City ______ State ______ Zipcode ______

Date of Birth ______ Daytime Phone (______)______ Previous Name ______

2) **PATIENT AUTHORIZES (HEALTHCARE PROVIDER/FACILITY):**

Name of Healthcare Provider or Agency ______ Health Care Provider Ph# ______

Address ______ Fax # ______

3) **TO DISCLOSE TO:**

Dr. Curtis Story MD of *Story Family Medicine* — Name of Healthcare Provider

941.875.9059 — Health Care Provider Ph#

17912 Toledo Blade Blvd Suite A Port Charlotte, FL 33948 — Address

941.206.2066 — Fax#

DELIVERY OPTIONS: Self Pick up Fax Mail to address above

To be picked up by, I hereby authorize: ______________________(Photo ID required)

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From __________ (month/year) to __________ (month/year)

(If left blank, information from the past (2) years will be disclosed)

5) **INFORMATION TO BE DISCLOSED:**

- ☐ All medical records related to (specify condition, treatment, etc.): ______________________
- ☐ All billing records related to (specify condition, treatment, etc.): ______________________
- ☐ Radiology films/images (specify test): ______________________
- ☐ Specific records/information as follows: ______________________

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I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date / event: ______________________
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (Check all that apply - **copy fees may apply**) ☐ Further Medical Care ☐ Legal Investigation /Action ☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ Other: ______________________

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies.** In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. If you have issues receiving your records or information or need assistance in filing a civil rights or health information privacy complaint, please email OCR at OCRMail@hhs.gov or call 1-800-368-1019 for more information.

9) **SIGNATURE OF PATIENT / LEGAL REP:** ______________________ **DATE:** __________

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:

Signature/ID verified ☐ Yes ☐ No Completed by: ______________________ *Name /Title*

Date Released: __/__/_____

___#of Pages

___#of CD(s)

Other: ______________