ARCHANGEL MICHAEL HEALTH, PA

Authorization to Release or Obtain Medical Records

Patient Information

Full Name:

Date of Birth:

Phone Number:

Last 4 Digits of SSN (optional):

Dates of Service Requested:

Specify 'All dates' or provide date range

Release Records

FROM:

Facility/Provider Name & Address:

Phone:

Fax:

TO:

Recipient Name & Address:

City, State, ZIP:

Phone:

Fax:

Email (if applicable):

Purpose & Delivery

Purpose of Disclosure:

- ☐ At the request of the individual
- ☐ Other (specify): _____

Delivery Method:

- ☐ Paper Copy
- ☐ Electronic Media
- ☐ Encrypted Email
- ☐ Unencrypted Email (I understand privacy risks)

Expiration

> This authorization expires 180 days from signature date unless specified below:

Expiration Date:

or Event:

Special Cases

USCDI Release (if applicable):

Includes Sensitive Information (alcohol/drug abuse, genetic testing, psychiatric, HIV/AIDS)

If excluded, specify:

Information to Be Disclosed

- ☐ **All Pertinent Records** (Includes items below unless specifically excluded)
- ☐ Consultation
- ☐ Discharge Summary
- ☐ Medication List
- ☐ Operative Report
- ☐ Pathology Report
- ☐ ER Report
- ☐ EKG Report
- ☐ History & Physical
- ☐ Lab Report
- ☐ Problem List
- ☐ Radiology Report
- ☐ Progress Notes
- ☐ Other (specify): _____

Understanding & Acknowledgments

1. I understand that by signing this form, I am authorizing Archangel Michael Health, PA to release or obtain my medical records as indicated above.
2. This authorization is voluntary and not required for treatment.
3. I may revoke this authorization in writing at any time, except for actions already taken.

4. Information disclosed may be redisclosed by the recipient and no longer protected by HIPAA if not required.
5. I may be charged a reasonable fee for records per state and federal guidelines.
6. I have the right to receive a copy of this signed authorization upon request.

Marketing & PHI Sale (if applicable): ◯ Yes ◯ No – I understand if financial remuneration is involved, it will be described here:

If you authorize exchange of PHI for marketing/sale, initial here: _____

Signature

I have read and understand the terms of this Authorization. I hereby voluntarily authorize the use or disclosure of my health information as described above.

Patient/Representative Signature: _____ **Date:** _____

Printed Name: _____ **Relationship (if not patient):** _____

If signed by someone other than the patient, please provide documentation proving legal authority (Power of Attorney, legal guardian, etc.).

For Practice Use Only

Received By: **Date:** **Verification/ID:**

This Authorization complies with HIPAA and Florida state law.

For questions or to revoke authorization: **Archangel Michael Health, PA**
Phone: (352) 441-9110 | Secure Fax: (352) 441-9114 | Secure Email: manager@archangelmichaelhealth.com

Archangel Michael Health
Healing with Heart & Science