

Medical Records Release Form
AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

[] FROM OR [] TO
Brevard Ear, Nose and Throat Center
1099 Florida Avenue S.
Rockledge, FL 32955
(P)321-632-6900 (F)321-639-7222

Patient Name: _____

DOB: _____

METHOD OF DISCLOSURE:

[] Pick up at office [] Mailed [] Fax #: _____

[] Medical Facility/Physician _____

Address: _____

Phone: _____ Fax: _____

[] Email Address: *(please note that emailing may not be a secure method of communication)*

Effective Period

This authorization for release of information cover the period of healthcare from:

A: _____ to _____ OR B: [] All past, present and future periods

INFORMATION TO BE DISCLOSED: (Initial Selection)

____ Progress Notes/History and Physical notes

____ Consultations

____ Diagnostic Test Reports (Specify) Type of test(s) _____

____ Other: (specify) _____

PURPOSE OF DISCLOSURE:

[] Continuity of Care [] Personal Use [] Other(specify) _____

May NOT include information related to (please initial): _____ HIV/AIDS _____ Mental Health

____ Drug and/or Alcohol Abuse _____ Genetic Counseling/Testing Information

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOICATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Client/Legal Representative Signature

Date

Printed Name Legal Representative's Relationship to Client

Witness (optional)

Date