

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD**

**PATIENT INFORMATION**

This authorization is for the release of medical information.

**PATIENT'S NAME** \_\_\_\_\_  
Last First M.I.

**ADDRESS** \_\_\_\_\_

**BIRTH DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **DAYTIME TELEPHONE NUMBER** \_\_\_\_\_  
Month Day Year

**SOCIAL SECURITY NO.** \_\_\_\_\_

**ORGANIZATION PROVIDING INFORMATION:**

\_\_\_\_\_  
Name of person or organization **releasing** information

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**ORGANIZATION REQUESTING INFORMATION:**

\_\_\_\_\_  
Name of person or **organization requesting** information

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**INFORMATION TO BE DISCLOSED:**

- Medical Notes/Summary  Operative/Procedure Reports \_\_\_\_\_  Pathology \_\_\_\_\_  
 PAP/HPV type  Mammograms/Sonograms (report only, no films)  Pelvic Sono  Bone Density  CXR / EKG  
 Recent Lab  All Medical Records – limited to 2 years  Other: \_\_\_\_\_

**SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:**

**ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS** are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

**AS PART OF THE MEDICAL RECORDS CHECKED ABOVE, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS STRICKEN:**

HIV/AIDS related information and/or records

Mental Health information and/or records

Sexually transmitted diseases

Drug/alcohol diagnosis, treatment or referral information

**SIGNATURE:** \_\_\_\_\_  
Patient or legal representative

**DATE:** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD**

**PURPOSE OF DISCLOSURE:**

Continuing medical treatment    Residence Relocation    Second Opinion    Patient Request

**For purposes other than Treatment, Payment and Operations:  
(Patient is to receive a copy of the Authorization)**

Research    Disability Insurance    FMLA    Life Insurance

Marketing Promotion: I have been informed Florida Institute for Reproductive Medicine \_\_\_\_\_ is \_\_\_\_\_ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

Other (please specify): \_\_\_\_\_

I understand that this authorization will expire **one year** from the date of signature below.

**RIGHT TO REVOKE AUTHORIZATION:**

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. I HEREBY RELEASE FLORIDA INTITUTE FOR REPRODUCTIVE MEDICINE. FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED ABOVE.

**AUTHORIZATION & SIGNATURE:**

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release Florida Institute for Reproductive Medicine from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. *For patients and governmental entities:* 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. *For other entities:* up to \$1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

Printed Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ Social Security #: \_\_\_\_\_

Printed Name of Parent, Guardian or Legal Representative: \_\_\_\_\_

**Parent, Guardian or Legal Representative Signature:** \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ **Records are needed by:** \_\_\_\_\_ (date)

**Send by:**  Fax \_\_\_\_\_ (Patient must initial approval)    Mail    Patient will pick up    Electronic format if EMR