PANCARE OF FLORIDA, INC.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:_____ Social Security #:_____

Date of Birth:_____ Home Phone:_____ Cell/Work Phone:_____

Address:_____ City/State/Zip:_____

Email Address:_____

I request and authorize records FROM:	To be released TO:
Name_____	Name_____
Address_____	Address_____
City/State/Zip_____	City/State/Zip_____
Phone #_____ Fax #_____	Phone #_____ Fax #_____

For the purpose of: □ Continuity of Care □ Personal Use □ Other_____

Records will always be delivered via user friendly CD or secure fax unless notated here: □ Please send printed copies via postal mail

Date Range:_____ to _____

□ Office Notes □ Cardiology/EKG Reports □ Immunizations

□ Lab/Pathology Reports □ Operative/Procedure Reports □ Radiology/X-Ray/MRI Reports

□ Other_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

In addition, I authorize the disclosure of any information related to the following (initial, if it is OK to release this information):

_____ Sexually transmitted disease
_____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Behavioral or mental health services _____ Treatment for substance abuse

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Office Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that this authorization will expire one year from the above date unless I specify a date. I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative Date

Expiration Date:_____