AMANA MEDICAL CENTER
FAMILY & URGENT CARE MEDICINE
www.AmanaMedicalCenter.com Email: info@amanamedicalcenter.com

220 Alafaya Woods Blvd. Ste 1000, Oviedo, FL 32765
Tel: 407-542-7335 Fax: 407-542-7338

Date: ---/---/------

Medical Records Release Form

I hereby authorize the use & disclosure of my protected health information as follow:

Patient Name: **Date Of Birth:**

This authorization applies to all health information pertaining to any medical history, physical condition, mental, HIV results, Sexual abuse, Alcohol / Drug treatment & Psychotherapy notes.

I have some Limitations on the information you may release:

_____

The reasons or purposes for this release of information are as follows:

_____

Persons/ Doctors/ Clinics/ organizations authorized to use or disclose the information:

NAME: _____

Tel Number: _____ Fax Number: _____

Persons/ Doctors/ Clinics/ organizations authorized to use or receive the information:

Name: Amana Medical Center

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).
Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

Patient Signature [or parent, guardian or legal representative]:

_____ **Date:** _____

I understand that you will provide this information within 1-5 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Florida Medical Board.