Altamonte Medical Group

1200 West State Road 434, Suite #112 Longwood, FL 32750 ph: 407-869-8747 fax: 407-869-8108

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name _____ Medical Record # (If known)_____

Date of Birth __/__/__

I authorize the following organization to release information as stated below from the patient health information record:

Information to be released *FROM*:	Information to be released *TO:*
○ **Altamonte Medical Group**	○ **Altamonte Medical Group**
○ _____ Organization	○ _____ Organization
___ _____ Street Address . _____ City, State, Zip	___ _____ Street Address City, State, Zip
_____ / _____ Phone Fax	_____ / _____ Phone Fax

Information to be Released

Dates of Service for Records Requested: Beginning _____ Thru _____

___Discharge Summaries ____Operative Reports ___Radiology Reports ___Lab/Pathology Reports ____Cl1ntail Notes

___Othet (please specify) _____

Purpose of Release

___ Continuing care ___ Copies for own use ___ Transfer to another provider ___ Legal ___ Coordination with school

___ Other (please specify) _____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90 days from the date signed below unless another date or event is entered here _____.
(Note: If the disclosure is to an employer or financial institution, this authorization will expire 90 days from the date signed by you.)

Sensitive Records may require specific patient authorization. Please check the applicable line(s) below to request the following records:

___ Mental Health Treatment (including pain management) ___ Sexually Transmitted Diseases ___ AIDS/HIV Treatment ___ Alcohol/Drug Abuse Treatment

Signature of Patient/Legal Representative

_____ Date _____ Signature of Patient/Legal Representative _____ Relationship to Patient

Signature of Minor Patient Required for the Following Records

Minor: A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2)Substance abuse and mental health treatment (age 13 and older)

_____ Date _____ Signature of Patient/Legal Representative _____ Relationship to Patient