The Villages Health

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

PATIENT INFORMATION:

Patient's Name**:** _____ Date of Request: _____
Address: _____ Date of Birth: _____
Home Phone:_____ Cell Phone:_____
Last 4 of Social Security: _____ Email:_____
*Authorized Representative (if other than the patient): _____
*Authority of Authorized Representative: ☐ Guardian ☐ Health Care Power of Attorney ☐ Health Care Surrogate ☐ Parent of Minor
☐ Representative of Deceased Patient ☐ Other _____

Information to be Released:

☐My Complete Medical Record ☐ Specified Records for Date(s) of Service: ____/____/____ **to** ____/____/____
☐ Provider Name(s): _____ ☐ Discharge Summary ☐ Lab Results
☐ History & Physical Exams ☐ Emergency Room Records ☐ Operative Reports/Consults ☐ Imaging Reports/Films
☐ Physician Progress Notes ☐ Other Records (specify)_____

INFORMATION FOR REQUEST/RELEASE (CIRCLE ONE):

REQUEST: REQUESTING PATIENT RECORDS *FROM* OUTSIDE FACILTY
RELEASE: RELEASING PATIENT RECORDS *TO* OUTSIDE FACILITY
This section to be completed if records will be requested or released to or from another medical facility/practice/provider *to* The Villages Health.
Medical Facility Practice/ Provider Name: _____
Contact Name: _____ Phone: _____
☐ Mail Address: _____ City**:**_____ State: _____ Zip _____
☐ Fax: _____

Records to be sent to: The Villages Health Attn: Medical Records
900 Main Street, Suite 204 Lady Lake, FL 32159
(Phone) 352-674-8700 (Fax) 855-604-6305

Purpose of Disclosure: ☐ Continuing Medical Treatment/Continuity of Care ☐ Other (Please Specify) _____

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulations. 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 regulations 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.

IN ADDITON TO ANY RECORDS CHECKED ABOVE, THE FOLLOWING INITIALED RECORDS MAY BE RELEASED:

☐ Behavioral/Mental Health Information _____ (please initial) ☐ Substance Abuse Information_____ (please initial)
☐ Sexually Transmitted Disease Information _____ (please initial) ☐ Immune deficiency syndrome (AIDS), or Human Immunodeficient Virus (HIV) _____ (please initial)

Right to Revoke Authorization: I may revoke this authorization in writing at any time to the practice, except to the extent that the information has been released in the execution of this authorization. I further understand that I have a right to receive a copy of this authorization upon request.
Authorization: I hereby authorize the use or disclosure of my individually identifiable health information as described. 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 except as provided by law. I understand that information released in response to this authorization could potentially be re-disclosed and may no longer be protected by federal privacy regulations. I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. I understand that this authorization will expire one year from the signature date below.

_____ _____
Patient Name (Guardian) **Date**