The Villages Health®

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient Information

Patient's Name _____ Date of Request _____ Home Phone _____

Address _____ Date of Birth _____ 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

☐ Specified Records for Date(s) of Service: ____/____/____ *to* ____/____/____

☐ Provider Name(s) _____

☐ Last History & Physical Exams ☐ Last Emergency Room Records ☐ Last Operative Reports/Consults ☐ Last Imaging Reports/Films

☐ Last Physician Progress Notes ☐ Other Records (specify) _____

Information for Request/Release (Circle One):

REQUEST: Requesting Patient Records *From* Outside Facility 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 Code _____

☐ 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 addition 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.

_____ _____

Signature of Patient or Patient's Authorized Representative Date