AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient Information

Patient's Name ______________________ Date of Request ______________ Home Phone ______________

Address ______________________ Date of Birth ______________ Cell Phone ______________

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) ______________

SUBSTANCE USE DISORDER/TREATMENT, AIDS/HIV, MENTAL HEALTH, & GENETIC INFORMATION

Unless otherwise indicated below, I hereby specifically authorize the release of psychological, psychiatric, substance use disorder and treatment information, sexually transmissible disease information, including human immunodeficiency virus ("HIV") testing/treatment and AIDS related information, and genetic information as it concerns the above-referenced patient. I specifically authorize the disclosure of genetic information, behavioral/mental health information, substance use disorder information ("SUD"), sexually transmitted disease information ("STD"), immune deficiency syndrome ("AIDS"), and Human Immunodeficient Virus ("HIV") information, unless indicated here:

DO NOT release: ______________________

Right to Revoke Authorization: I may revoke this authorization by submitting my request in writing to the department where I submitted this authorization but understand that such revocation will not apply to actions already taken by my healthcare provider prior to my revocation.

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. I further understand that I have a right to receive a copy of this authorization upon request. I understand that information released in response to this authorization could potentially be re-disclosed and may no longer be protected by privacy laws. I understand that my provider may charge a reasonable fee, as allowed by law, for a copy of my 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