

SOUTH LAKE MEDICAL CENTER

DR. SHAZIA NASIR

1950 HOSPITAL VIEW WAY

CLERMONT, FL 34711

TEL# 352-243-3443 • FAX# 352-243-3044

AUTHORIZATION TO RELEASE/REQUEST MEDICAL INFORMATION

PATIENT NAME: (PLACE LABEL HERE)

ADDRESS:

PHONE #:

DATE OF BIRTH:

RELEASED FROM:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

RELEASED TO:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

INFORMATION REQUESTED: (PLEASE CHECK)

COMPLETE HEALTH RECORD

VISIT SUMMARY

HISTORY & PHYSICAL

CONSULTATION REPORTS

DIAGNOSTIC IMAGING

LABORATORY TESTS (PLEASE SPECIFY) _____

OTHER (PLEASE SPECIFY) _____

MEDICATIONS LIST

PROGRESS NOTES

PROCEDURE REPORTS

EKG

IF APPLICABLE, I ALSO GIVE PERMISSION FOR THE FOLLOWING TO BE DISCLOSED (PLEASE INITIAL):

AIDS/HIV TREATMENT

BEHAVIORAL HEALTH SERVICES / PSYCHIATRIC CARE

TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE

SEXUALLY TRANSMITTED DISEASES (STD)

GENETIC COUNSELING / TESTING

WHY DO YOU NEED THESE RECORDS?

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE PROVIDER(S) OF CARE. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO REVIEW OR CONTEST A CLAIM. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: _____.

IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT, OR CONDITION, THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS. IF THIS AUTHORIZATION PERTAINS TO ONESELF AS THE PATIENT, THE EXPIRATION DATE CAN BE DOCUMENTED AS UNLIMITED. IF DOCUMENTED AS SUCH, IT IS THE RESPONSIBILITY OF THE INDIVIDUAL TO NOTIFY THE PRACTICE OF ANY LIFE CHANGES, I.E. GUARDIANSHIP, SO THAT APPROPRIATE DOCUMENTATION IS GIVEN FOR THE CHANGE.

- ❖ I UNDERSTAND THAT ANY DISCLOSURE OF HEALTHCARE INFORMATION CARRIES WITH IT THE POTENTIAL FOR UNAUTHORIZED AND FUTURE RE-DISCLOSURES, AS ALLOWED BY HIPAA AND OTHER FEDERAL PRIVACY RULES. IF I HAVE QUESTIONS ABOUT DISCLOSURES OF MY HEALTH INFORMATION, I CAN CONTACT MY PROVIDER OF CARE.
- ❖ THIS FACILITY, ITS EMPLOYEES, OFFICERS, AND PHYSICIANS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.
- ❖ FEES FOR COPIES OF MEDICAL RECORDS IN PAPER OR ELECTRONIC ONTO DISK TO BE CHARGED IN ACCORDANCE WITH THE STATE OF FLORIDA FEE SCHEDULE AND THE ACTUAL COST OF POSTAGE.

SIGNATURE OF __PATIENT__ PERSONAL REPRESENTATIVE

PRINTED NAME

IF PERSONAL REPRESENTATIVE-RELATIONSHIP TO PATIENT

DATE