**Medical Release of Information**

I authorize the release of my medical records by the organization or physician listed below

Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician (s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please fax requested documents to Ambareen Internal Medicine (AIM) at (352)331-2915 or mail (for files over 30 pages).**

***The type of information to be disclosed:***

□Lab Reports □ Pathology Reports □ Operative Report □ Discharge Summary

□ History & Physical □ Optical Reports □ Care Plan □ Progress Notes: \_\_\_\_\_\_\_\_\_\_\_\_

□ Immunizations □ Mental Health □ Radiology Reports □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Entire Medical Records** (including records regarding AIDS/HIV, other communicable diseases, alcohol and substance abuse treatment and/or any records marked as Confidential)

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Signature (parent/guardian/Representative) Relationship to patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

*I understand that this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date, I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that actions have been taken based on it. I understand the revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any fees associated with my records*