AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

FROM OTHER HEALTHCARE FACILITIES

Patient Name: ____________________________________

Patient DOB: _____________________________________

Name of Healthcare Facility from which Records are Requested:
____
Address: ____
City: ____________________ State: _________ Zip:__________
Phone: __________________ Fax: ________________________

Dates of Treatment Requested:

____

Reason for Disclosure:

____

MAIL INFORMATION TO: OR FAX INFORMATION TO :

Release Medical Information to: **First Choice Urgent Care**

1945 W CR 419 Ste 1101

Oviedo, FL 32766

Ph: 407-366-2890 Fax: 407-366-2843

I hereby authorize First Choice Urgent Care to obtain the health information indicated below that is contained in my patient records to the Recipient named above. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization**. **Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record**

This consent is subject to revocation at any time except to the extent the action has been taken thereon.
This authorization and consent will expire one year from the date of authorization written below.
Your health care (or payment for care) will not be affected by whether or not you sign this authorization.
Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

Signature_______________________________________ / _____________________________________

Date ______ / ______ / ______

*Signature of Patient/Patient's Personal Representative** Printed Name Date Signed Relationship if not Patient **If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative* ***MUST*** *accompany the request (i.e. court appointed guardian, durable power of attorney for ealth care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*