

**FAMILY PRACTICE OF CENTRASTATE
(PATIENT RECORDS TRANSFERRING INTO PRACTICE)**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named healthcare provider to release the information or records specified to the provider below upon request in person or by mail to the address specified at the time of the request.

Provider: (name and address) Family Practice of CentraState	Patient: SS#: DOB:
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FROM: (SPECIALIST NAME) _____

RECORDS AUTHORIZED TO BE RELEASED:

<input type="checkbox"/> Admission history and physical <input type="checkbox"/> Discharge summary <input type="checkbox"/> Complete hospital chart <input type="checkbox"/> Office notes <input type="checkbox"/> Outpatient records <input type="checkbox"/> Psychiatric and other mental health records <input type="checkbox"/> Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released) <input type="checkbox"/> Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me. (These records should be redacted to protect information pertaining to other patients) <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Lab reports <input type="checkbox"/> Radiological images <input type="checkbox"/> Consultation notes or reports <input type="checkbox"/> Complaints or grievances filed, with Responses or dispositions
Extent or nature of records to be released: _____ (example, specific hospitalization or visit)	

This information will be used for the purpose of:

<input type="checkbox"/> Investigating an allegation of abuse <input type="checkbox"/> Providing advocacy services <input type="checkbox"/> Other activities at the request of the individual <input type="checkbox"/> Continuity of care (changing providers)	<input type="checkbox"/> Verifying my eligibility for services offered by the _____ <input type="checkbox"/> Legal representation
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This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider or to the _____,

But that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization _____ and that my healthcare or payment for care will not be affected by my refusal. Patient/Representative Signature Date
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information. Name of Representative (print)
- I am entitled to receive a copy of this authorization. Relationship to Patient
- A copy of this authorization may be utilized with the same effectiveness as an original.