

Authorization for Release of Medical Records

To: MEDICAL RECORDS DEPARTMENT

Telephone: _____

Fax: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

This authorization includes release of information concerning AIDS/AIDS-related conditions, HIV/HIV-related conditions, AIDS/HIV testing, drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric and or psychological conditions.

Person/Organization Providing the Information

Person/Organization Receiving the Information

Internal Medicine & Pediatrics of Tampa Bay
10111 Wilksy Blvd.
Tampa, FL 33625
Phone Number: (813) 961-2222
Fax Number: (813) 961-2220

Specific description of information requested

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on 12/31/2013. **Initials:** _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Initials: _____

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Signature: _____

Date: _____

If above signature is not the patient's, please print name and relationship to patient:

Name of responsible party: _____ Relationship: _____