

# 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 Wilsky 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: \_\_\_\_\_