BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

Authorization For Release Of Confidential Information

I, _____, hereby authorize to release all Protected Health Information (PHI) including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC, AIDS, or for care paid for out-of-pocket information or any other records of a sensitive nature:

_____ From: _____ To: _____ To: _____ From:

_____
(Name of hospital, agency, or individual)

_____
(Address)

_____

Bradley M. Block, M.D. Amy J. Nation, D.O.
Craig P. Chase, M.D. Susan G. Smolen, M.D.

2441 State Rd 426, Suite 2011
Oviedo, Florida 32765
(407) 678-6888 **FAX: (407) 359-5454**

To expedite the processing of incoming medical records into patient charts in our electronic medical record system, please <u>FAX</u> all records to us or send on <u>CD</u> .

My records are to be released for the purpose of: _____
(Reason for Release of Records)

Send records from: _____(date) to: _____(date)

__ All records, or __ Radiology Reports and Laboratory Reports __ H & P's, Consults, Medical Summaries

__ Immunization Records __ Other:

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Block, Nation, Chase & Smolen Family Medicine has acted in reliance upon this authorization. My written revocation must be submitted to Block, Nation, Chase & Smolen Family Medicine's Privacy Officer at 2441 West State Rd 426, Suite 2011, Oviedo, Florida 32765.

I understand that this consent is revocable upon written notice to Block, Nation, Chase & Smolen, Family Medicine except to the extent that action has already been taken on this authorization. This authorization shall remain valid for a reasonable time (90 days) to accomplish the purpose for which it is given. In accordance with Federal and State regulations, information pertaining to drug or alcohol abuse, HIV testing, AIDS, or for care paid for out of pocket, is prohibited from further disclosure to other parties without written consent from the patient. A general authorization for "Release of Information" by another party is not sufficient for this purpose.

_____ _____
(Date of Authorization) (Patient's Signature in Full)

_____ _____
(Date of Birth) (Social Security Number)

_____ _____
(Witness) (Parent, Legal Guardian or Authorized Representative)

Specific records released as requested:

By: _____

Date Mailed: _____