ProHealth
Family Physicians
3100 17th Street • St. Cloud, FL 34769
PH 407-892-0009 • 407-892-3285 FX

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____
Address:_____
Date of Birth:_____ Phone Number:_____

The above named patient does hereby authorize **Pro Health Family Physicians** to **release** his/her records **to**:

Physician/Person:_____
Address:_____
Telephone:_____Fax:_____

Or The above named patient does hereby request **Pro Health Family Physicians** to **obtain** records **from:**

Physician/Office:_____
Address:_____
Telephone:_____Fax:_____

I understand that this authorization extends to all or any part of the records designed above, which may include psychiatric information, and/or genetic counseling/testing, and /or alcohol/drug abuse, and/or STD/Communicable Diseases and/or AIDS, and/or may include the result of an HIV test or the fact the an HIV test was performed. **I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.**

May NOT include information related to (Please Initial):
_____HIV/AIDS _____Mental Health _____Drug and/or Alcohol Abuse
_____Genetic Counseling/testing _____STD/Communicable Diseases

The Following information is to be disclosed:
___Progress Notes ___Laboratory Results ___Radiology Report ___Immunization Records
___3 Years /Abstract Records (H&P, Discharge Summary, Consultation, Operative & Procedure Reports EKG's, Laboratory, X-ray and Imaging reports) (**New Patients**)

Date(s) of Service:_____Reason For Release:_____

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action is already taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Pro Health Family Physicians may not condition the provisions of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provisions of the authorization. This authorization automatically expires one hundred eighty (180) days form the date its signed or as otherwise specified_____.

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date

************If Over 25 Pages Please Mail************
FEE FOR RECORDS 1.00 PER PAGE UP TO 25 PAGES & 25¢ FOR EACH ADDITIONAL PAGE