DocCare
MEDICAL CLINIC

Patient Authorization for Release of Health Records to External Parties

I authorize_____to disclose information from the health records of: _____DOB: _____
(patient)

The information is to be disclosed to: **DOCCARE MEDICAL CLINIC 3505 E HILLSBOROUGH AVE, STE 102 TAMPA, FL 33610 FAX:813-415-0200. TEL:813-415-0100**

I authorize this information to be disclosed in the following ways:
Written/Photocopy/Paper Electronic Format Verbal Fax Electronic Mail

Purpose of the disclosure: _____

Dates of Treatment: From: _____To: _____

Specific reports to be disclosed:

Progress Notes	Laboratory Reports	Operative Reports
Discharge Summary	Radiology Reports	Consultation Reports
X-ray films or other images	Photographs/Videotapes	Records from other facilities

Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
Other (Specify):_____

I give specific authorization to disclose the following information:

HIV test results	Documentation of AIDS diagnosis
Drug and alcohol abuse treatment records	Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Florida Diabetes and Endocrine Associates LLC inwriting.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Florida privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)