1834 SW 1st Ave, Suite 201
1813 SW 1st Ave, Ocala, Fl 34471
Phone: (352) 732-9888
Fax: (352) 732-0490

Medical Records Release Authorization

Patient Name: _____ DOB: _____

I hereby authorize and request _____ to release medical information concerning my medical care to Express Care of Ocala and affiliates for the purpose of:

_____

_____

(Specific purpose of disclosure of record)

_____ All Records
_____ Eye Exam
_____ Mammogram
_____ Most recent Laboratory Testing Results
_____ Recent Colonoscopy
_____ Other

_____ Bone Density
_____ Last 3 Progress Notes
_____ Most recent Diagnostics Test Results
_____ Problem List / Medications List

I understand that the information released may include information concerning HIV testing or treatments of AIDS and/or AIDS related conditions, drug and/or alcohol abuse (or related conditions), and mental health concerns.

I understand the use and/or disclosure of my individual health information as described above and that this authorization will expire, without my express revocation, either one (1) year from the date of signing or, if I am a minor, on the date I become an adult, according to the state law, whichever occurs first.

I understand that authorization for the disclosure of this health information is voluntary, I can refuse to sign this authorization, and that this authorization is revokable upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation and that it may be re-disclosed by the recipient.

The facility, its employees, officers, Advanced Practice Providers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.

_____ _____

Patient Signature Date