Okeechobee Family Practice

Medical Records Release

1713 HWY 441 N Suite D

Okeechobee, FL 34972

P: (863) 467-8771 F: (863) 467-2825

I. INFORMATION DISCLOSED BY:

Person/Facility: _____

Address: _____

Phone: _____ **Fax:** _____

II. INFORMATION DISCLOSED TO:

Person/Facility: _____

Address: _____

Phone: _____ **Fax:** _____

III. METHOD OF DISCLOSURE:

☐ **US MAIL** ☐ **FAX**

Address: _____

Fax: _____

IV. DISCLOSE:

From (Date): _____ **To (Date):** _____

☐ Progress Notes ☐ Labs ☐ Imaging and other tests ☐ Immunizations

☐ Entire Medical Record ☐ Other; Specify: _____

V. PURPOSE:

☐ Continuation of Care ☐ Personal Use ☐ Other: _____

Please read carefully:

By signing this release, you acknowledge your informed consent to disclosure of your protected health information and your rights to revoke this authorization at any time. To revoke this authorization, you must submit in writing your request to revoke; you understand that the revocation will not apply to information that has already been disclosed with your consent prior to revocation. You agree that revocation does not apply to insurance companies. By signing this release, you agree to disclosure of protected health information including STD, HIV/AIDS, substance use/abuse records, and psychological testing/notes. This authorization for release/disclosure of protected health information will expire 12 months after signature date. You agree to a service charge for all printed records; $1.00 per page up to 25 pages, all other pages thereafter will cost 0.25 cents per page.

PATIENT: _____ **DOB:** _____

Signature: _____ **Date:** _____

Legal Guardian: _____

Signature (Guardian) : _____