Harris Internal Medicine

5900 Turkey Lake Road, Suite A, Orlando, FL 32819
Phone: 407.351.9696 Fax: 407.351.8848

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Last 4 Digits of SSN #: __________

Address: ____

Date of Birth: ____________________ Phone #: ____________________

I hereby authorize Harris Internal Medicine to: **Obtain my records from:** ☐ **or** **Release my records to:** ☐

____

Name of Facility or Person Phone Fax

____

Street Address City State Zip Code

Dates of Service FROM: ____________________ Date of Service TO: ____________________

By signing below, I authorize the disclosure/release of the following information contained in my medical record:

☐ Complete Record ☐All Diagnostic Test Results ☐ Lab Only ☐ Radiology Only ☐ Billing Only

☐ Other (Please Specify) ____

The purpose for the release of information at the request of the individual is:

☐ Insurance ☐ Continued Treatment ☐ Personal Use ☐ Other (Please Specify)____________________

This authorization will expire on the following date, event or condition: ____________________

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

May NOT include information related to:

☐ HIV/AIDS ☐ Mental Health ☐ Drug and/or Alcohol Abuse

☐ Genetic Counseling/Testing ☐ Other (Please Specify) ____________________

If I fail to specify an expiration, event, or condition, the authorization will expire in one year. 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 has already been 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.

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Patient/Legal Representative or Parent/Legal Guardian Signature Date

☐ **I wish to revoke this authorization.** Signature: Date: