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PATIENT AUTHORIZATION/CONSENT FOR PRACTICE TO REQUEST/RELEASE PROTECTED HEALTH INFORMATION

_____ _____ _____
Patient Name Date of Birth MRN

By signing this release, I authorized Daniel W. McGrane, MDPA Specialists to: **(please check one and print legibly)**

☐ **Request records from: _____**
Phone: _____ Fax: _____
Address: _____
_____

☐ **Send records to: _____**
Phone: _____ Fax: _____
Address: _____
_____

☐ **Release records to patient**
☐ **Patient to pick up**
☐ **Mail to patient**

For the PURPOSE of: (**check all that apply)**
☐ Release to a specialist for continued medical care.
☐ Release to the patient for personal use.
☐ Release to an insurance company or agent.
☐ Due to leaving the practice or finding a new primary care doctor.
☐ Other (please specify): _____

PLEASE COMPLETE THE BELOW SPECIFIC INFORMATION

Dates of service requested: _____
Specific records or test results requested: _____

I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released. I understand that the party receiving my information might not be subject to HIPAA and might be allowed to disclose this information. The facility releasing the records does not require that I sign this authorization in order to receive services. This authorization will expire 180 days from the date signed if not otherwise indicated. I understand that records may be faxed or sent via mail. Daniel W. McGrane, MDPA Specialists reserves the right to charge copies of medical records as allowed by Florida and HIPAA laws. Pre-payment of medical record copies is required at .50 cents per page requested plus applicable postage fees. By signing this release, I authorized Daniel W. McGrane, MDPA Specialists to release my protected health information. I authorize release of all records, including any results of HIV testing and/or treatment as well as any records of alcohol and/or substance abuse treatment.

_____ _____
Signature of the Patient/ guardian/ legal representative Date Signed

_____ _____
Printed Name Relationship to Patient

To the recipient: 1) Any information regarding HIV test results is disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to who such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. 2) Any information regarding alcohol and/or substance abuse treatment may be protected by federal law, with re-disclosure prohibited without the consent of the person whom the information pertains.