Heart of Florida Health Center
2553 East Silver Springs Blvd Ocala, FL 34470
(352) 732-6599

Authorization for Release of Medical Records

INCOMING

Name of Patient (Type/Print)		Date of Birth	Phone number
Address	City	State	Zip

Please Select Location Fax/Number:

- ☐ **HFHC Main/Admin Office** Fax: 800-611-5078
- ☐ **HFHC Central** Fax: 866-797-7933
- ☐ **HFHC West** Fax: 866-849-6953
- ☐ **HFHC Belleview** Fax: 866-535-2843
- ☐ **HFHC Southwest-Marion Oaks** Fax: 877-914-4981
- ☐ **HFHC Reddick** Fax: 888-898-3621
- ☐ **HFHC Dunnellon** Fax: 877-882-9551
- ☐ **HFHC Beacon Point** Fax: 877-569-2091
- ☐ **HFHC College Park** Fax: (352) 390-8976
- ☐ **HFHC Referral** Fax: 888-842-4578
- ☐ **HFHC The Villages** Fax: 888-571-4152

Authorizes the Release of Protected Health Information to HFHC From:

Name of Health Care Provider/Plan/Other		Phone	Fax Number
Address	City	State	Zip

Information to be released.

- ☐ **Medical History Examination, Reports**
- ☐ **Laboratory/Pathology Reports**
- ☐ **X-ray Reports**
- ☐ **Treatments or Tests**
- ☐ **Consultations**
- ☐ **Immunizations**
- ☐ **Prescriptions**
- ☐ **Hospital/ER Records and Reports**
- ☐ **Entire Record**
- ☐ **Other (Specify): _____**

In compliance with Florida Statutes, which requires special permissions to release otherwise privileged information, please release records pertaining to (Initials required):

_____ HIV/AIDS
_____ STD
_____ Mental or Psychological Health
_____ Drug, Alcohol and/or Substance Abuse
_____ Genetic Diseases/Tests (DNA)

Choose Record Date Range (check only 1 box)

- ☐ Full Record
- ☐ Specific Dates of Service_____.

I understand that this authorization extends to all, or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), 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 designated above or otherwise required by law. The authorization will expire on the following date, event or condition: _____. **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 have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, by sending a written request to HFHC's Privacy Officer, and that I have the right to a copy of this authorization form. Privacy Officer, Heart of Florida Community Health Centers, Inc., 2553 E Silver Springs Blvd 34470

Signature of Patient (18 years and older) **Date**

Parent of Legal Guardian Signature (Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied) **Date**