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

Authorization for Release of Medical Records

OUTGOING

I, the undersigned, authorize: Heart of Florida Health Centers Inc. to release my health information as noted below.

Patient Information:

Name of Patient (Type/Print) | Date of Birth | Phone number

Address | City | State | Zip

Release information to:

Name/Facility | Attention to: | Phone | Fax Number

Address | City | State | Zip

Purpose of the Request:

- ☐ Personal
- ☐ Treatment
- ☐ Legal
- ☐ Disability
- ☐ Insurance
- ☐ Transfer/Reason: _____
- ☐ Other: _____

Record Date Range:

- ☐ Full record
- ☐ Specific Dates of Service_____.

Choose Delivery Method:

- ☐ Sent Securely (electronically) Email Address: _____
- ☐ Sent by mail.
- ☐ Fax: _____

Authorization to Release Sensitive Information:

Check and Initial each line		Initial each line
I ☐ **DO**	☐ **DO NOT** want information about **Mental Health** released	_____
I ☐ **DO**	☐ **DO NOT** want information about **HIV Tests and Related Information** released	_____
I ☐ **DO**	☐ **DO NOT** want information about **Alcohol and/or Substance Abuse** released	_____
I ☐ **DO**	☐ **DO NOT** want information about **Sexually Transmitted Disease** released	_____
I ☐ **DO**	☐ **DO NOT** want information about **Genetic Diseases/Tests DNA** released	_____
I ☐ **DO**	☐ **DO NOT** want information about _____ released	_____

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless of if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

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**

*Fees may vary based on page counts and delivery methods.