HEART OF FLORIDA HEALTH CENTER

2553 E. Silver Springs Blvd, Ocala, FL 34470 • (352) 732-6599
Fax: **1-800-611-5078**

Authorization to Release or Request Medical Records

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___ / ___ / ____

Phone Number: (_____) _____-_____ Email: _____

2. RECIPIENT OR SENDING FACILITY

I authorize the Heart of Florida Health Center to:

☐ Release my records to the individual/facility below

☐ Request my records from the individual/facility below

Provider/Facility/Recipient: Name: _____

Address: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

3. RECORD INFORMATION

Records to be released and/or requested *(Check all that Apply)*

☐ Entire Record ☐ Immunizations ☐ Imaging/X-rays ☐ Other (specify):

☐ Medical History ☐ Labs ☐ Prescriptions _____

Purpose of Request or Disclosure

☐ Personal Use ☐ Legal ☐ Disability

☐ Treatment / Continuity of Care ☐ Insurance ☐ Other: _____

Date Range of Records:

☐ Entire Medical Record ☐ Records from: _____ to _____ (dates)

4. PREFERRED DELIVERY METHOD: *(for external RELEASE only)*

☐ Paper copy (mail or pick-up) *A fee will apply $

☐ Encrypted Email (Secure)

☐ Fax (to medical offices only)

5. SENSITIVE INFORMATION RELEASE *Please check and initial each type of sensitive information you want released*:

Type of Info	Release/Request		Initials
Mental Health	☐ Yes	☐ No	_____
HIV/AIDS Testing or Related Info	☐ Yes	☐ No	_____
Alcohol and/or Substance Use	☐ Yes	☐ No	_____
Sexually Transmitted Infections (STIs)	☐ Yes	☐ No	_____
Genetic Testing/DNA Info	☐ Yes	☐ No	_____
Other: _____	☐ Yes	☐ No	_____

*All boxes must be completed even if information does not apply. *

6. AUTHORIZATION

By Signing below,** I **understand that sharing my health information is my choice. I do not have to sign this form to receive care. I can change my mind and cancel this permission at any time in writing, except if the information has already been shared. This form is valid for one year. I also understand that once my information is shared, it may not be protected by federal privacy laws and could be shared again. If I have questions, I can contact the person or organization listed on this form.

Patient (18+) Printed Name: _____ Signature: _____ Date: ___ / ___ / ____

Parent/Legal Guardian Printed Name: _____ Signature: _____ Date: ___ / ___ / ____

(Required for patients under 18 unless otherwise allowed by law. Legal documentation must be provided.)

--- For Office Use Only ---

Employee Receiving Request: _____ Employee Signature: _____ Date: _____

Verification Method (Check one): ☐ ID ☐ Known Patient ☐ Legal Representative Verified