

**(Facility Use Only) Patient ID: \_\_\_\_\_\_\_\_\_\_**

**Pages Released: \_\_\_\_\_\_\_\_\_\_**

**Fee: \_\_\_\_\_\_\_\_\_\_**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

North Florida

**Surgery Center**

Email to: [medicalrecords @nfsc-asc.com](mailto:medicalrecords@nfsc-asc.com) or fax to (850) 494-0065

Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name (First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send Records Attention to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_ Zip: .

For the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(List Reason for Releasing Information)

Release the following portion(s) of patient’s medical records during the time period of:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR (select)**

* **Entire Medical Records**
* Operative Report
* History and Physical
* Progress Notes
* Nurse’s Notes
* Physician Orders
* Itemized Billing Statement
* EKG
* X-Rays
* Pathology Report
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will remain in effect for six (6) months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by patient at any time, but is NOT retroactive to release information made in good faith. By signing this authorization, the undersigned agrees NOT to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent or authorization.

PROPOSED NEW USE OF INFORMATION WITHOUT ADDITIONAL WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS IS PROHIBITED.

The undersigned hereby released the above-mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that if there is a charge for copies that such charges must be paid prior to release of copies. Additionally, I will bring valid identification, unless noted otherwise, as proof of identification for release of medical records.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_