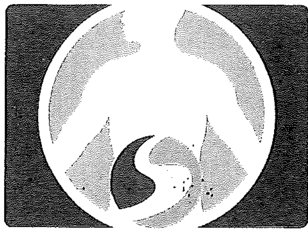

Henry Levine M.D.
F.A.C.P., A.G.A.F.

William B. Ruderman, M.D.
F.A.C.P., F.A.C.G.

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MBA

Ehsan Rafiq, M.D.

Jacqueline Larrea, ARNP, NP-C

Rose Ray, ARNP

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Medical Records Department Fax # 407-447-5224

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of medical records, summary or narrative of my protected health information, to the physician, person facility and/or entity listed below.

This is to authorize Dr. ____________________ to release records.

Patient Name: ____________________________________

Social Security#: ____________________________________

Date of Birth: ____________________________________

TYPE OF INFORMATION REQUESTED

- ☐ **Most Recent Office Notes**
- ☐ **Most Recent Labs/Pathology Reports**
- ☐ **Most Recent Radiology Reports**
- ☐ **All Mentioned Above**
- ☐ **Other ______________________________**

This information is being requested to be disclosed for the following purpose: ______________________________

METHOD OF RELEASE

- ☐ **Patient Picked Up Records. Date: ______________**
- ☐ **Faxed Records to Patients.**
  Fax# ________________Date: ______________
- ☐ **Faxed Records to Doctors Office.**
  Dr. ________________Date: ______________
  Fax# ________________
- ☐ **Mailed Records to:**
  NAME: ______________________________
  ADDRESS: ______________________________
  ____

I UNDERSTAND THAT THIS AUTHORIZATION:

- **Prohibits further use or disclosure of information being release beyond the specific limits of this authorization;**
- **Please take note that these releases can take up to 48 hours to be processed.**
- **Includes all medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition, including psychological or psychiatric impairment, drug use and/or alcoholism or Acquired Immunodeficiency Syndrome (AIDS), or test for infection with Human Immunodeficiency Virus (HIV).**
- **Expires one (1) year from the date of signature or when the care event is complete.**
- **This authorization may be revoked in writing any time prior to submission of records at my request.**
- **I understand that I have the right to a copy of this authorization..**
- **I understand that failure to provide all information may invalidate the authorization.**
- **I understand that any individual may refuse to sign the authorization and by doing so this will not prevent any further treatment.**
- **Information released to third party other than a healthcare provider may not be subjected under HIPPA laws.**

Signature: ______________________ Date: ______________

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