Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. **PATIENT INFORMATION**

   Name:_____

   Address:_____

   _____

   _____

   Last four of SSN:_____

   Date of Birth:_____

2. **AUTHORIZATION FOR RELEASE.** I hereby authorize _____of_____ _____, to release, disclose, and deliver the medical information described below to:

   Authorized Recipient:
   Florida Surgical Clinic LLC
   701 Manatee Ave West Suite 105
   Bradenton, Florida 34205

3. **REASON FOR DISCLOSURE** _____

4. **SPECIFIC AUTHORIZATION** Circle either Yes or No specifically authorizing the release of only the following information:

   Mental Health Records: Yes or No

   Communicable Disease Records: Yes or No

   Alcohol or Drug Abuse Treatment: Yes or No

   Complete Health Records: Yes or No

I specifically authorize the release of the following information:

_____

_____

Dated: _____

Patient Signature:_____

Typed or Printed Name:_____

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5. **REDISCLOSURE.** This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

   This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45, CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the REDISCLOSURE requirements sent out above will apply to these records.

6. **VALIDITY.** I understand that this authorization will automatically expire on year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person of entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

I understand that information disclosed pursuant to this authorization may be subject to redisclousure by the recipient and may no longer be protected by Federal or State privacy laws.

Date: _____

Patients Signature:_____

Typed or Printed Name:_____