healthcare network

1454 Madison Avenue
Immokalee, FL 34142

Phone: (239) 658-3000 Fax: (239) 658-3077

Authorization for Release of Medical Records

Section I: Patient name

First: Middle: Last:

Social Security Number: DOB: Medical Record #

Section II: The information to be used or disclosed is as follows:

Date(s) of Treatment:

From To

(If date of treatment is blank all dates are included.)

- ☐ Physicals/Well exams
- ☐ Sick Visits
- ☐ Laboratory
- ☐ Immunization Records
- ☐ Radiology/ Reports
- ☐ OB/GYN
- ☐ Diabetic Information
- ☐ Episodic/ Progress Notes
- ☐ Radiology/ Films
- ☐ Cardiology/ EKG
- ☐ Tuberculosis
- ☐ Dental Records
- ☐ Other:

Super Confidential Information:

- ☐ HIV/ AIDS ☐ (Pt's Initials)
- ☐ STD ☐ (Pt's Initials)
- ☐ Genetic Data ☐ (Pt's Initials)
- ☐ Mental Health ☐ (Pt's Initials)
- ☐ Substance Abuse ☐ (Pt's Initials)

Consent for Minors: Minors are permitted to consent to medical care and treatment in the following situations. 1. A minor who is, or has been, married 2. An unwed pregnant minor consenting to the performance of medical or surgical care or services relating to her pregnancy 3. An unwed minor mother consenting to the medical or surgical care or services of her child. 4. A minor seeking voluntary substance abuse treatment services 5. A minor consenting to the examination and treatment of sexually transmitted disease. 6. A minor with a court order removing the disability of nonage.

Section III: What format would I like my records?

☐ CD ☐ Paper

How I would like my records forwarded:

☐ Mail ☐ Pick-up at:
Marion E Feather 1454 Madison Ave Immokalee, FL, 34142

Section IV: This information will be used for the following purpose:

- ☐ Personal/Self
- ☐ Attorney
- ☐ Workers Compensation
- ☐ Doctor
- ☐ Insurance
- ☐ Immigration
- ☐ Social Security
- ☐ Other:

SECTION V: I hereby authorize:

Healthcare Network of Southwest Florida to release the above medical information to the following individual or organization:

Name or receiving facility:

Address:

City:

State: Zip:

Phone #:

Fax # if medical facility:

I understand this disclosure will NOT include HIV/AIDS, STD, genetic data, mental health, and/or substance abuse, unless indicated and initialed to do so under "SUPER CONFIDENTIAL INFORMATION" located in box 1. I further agree to release the above named facility, its affiliates, employees, officers, and physicians from all legal responsibility and liability that may arise from the disclosure and/or unauthorized re-disclosure of such information. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information department. I understand that the revocation will not apply to the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in one (1) year from the signature date below. I understand that authorizing the disclosure of this health information is voluntary. I understand that the medical provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.54. I understand that I may be charged a fee of up to $1.00 per page plus handling charges as allowed by Florida law. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management 239-658-3000.

Section VI:

Signature of Patient: Date:

If you are the parent/Legal Guardian, sign below and state your relationship to the patient. Legal guardian must attach a copy of the document of authority.

Signature of Parent/ Legal Guardian: Date:

Relationship to the patient:

Signature of Witness: Date: