

Authorization to Release Medical Records

Date: _____

I authorize: **Carillon Sports and Family Medicine**
12225 28th St. North, Suite B
St. Petersburg, FL 33716
(727) 561-4303 (727) 561-9299

- To Obtain Records From
 To Send Records To

(Medical Facility/Medical Provider)

(Address)

(City, State, Zip)

(Telephone Number) (Fax Number)

Patient's Full Name

Date of Birth

Social Security Number

For the purpose of review/examination, I authorize you to provide the following information:

_____ Complete copy of medical record

_____ Specific information _____

I give permission to release any information related to:

_____ Substance abuse

_____ Psychiatric/mental health information

_____ HIV/AIDS information

Reason for Transfer Request

- Continuity of care Moved from the area Insurance issues Problem with staff/physician
 Other _____

This authorization will expire one year from the date signed. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer covered by HIPAA.

Patient or Legal Guardian Signature: _____

Relationship to the Patient: _____

Name at time of treatment if other than above: _____

Date of Treatment(s): _____