AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

PATIENT'S NAME ____
Last First M.I.

ADDRESS ____

DATE OF BIRTH ______/______/______ (Month Day Year) SOCIAL SECURITY NO. (last 4 only) ______________

ORGANIZATION PROVIDING INFORMATION:

____
(name of person or organization **releasing** information)

____

____

PHONE: ______________ FAX: ______________

ORGANIZATION REQUESTING INFORMATION:

UROLOGY ASSOCIATES OF NORTHEAST FLORIDA
(name of person or organization **requesting** information)

1715 VILLAGE WAY

ORANGE PARK, FL 32073

PHONE: (904) 264-8418 FAX: **(904) 264-9692**

INFORMATION TO BE DISCLOSED:

☐ ALL MEDICAL RECORDS (LIMITED TO 3 YEARS) ☐ OTHER: ______________

PURPOSE: ☐ Moving/Relocation ☐ Continuing Treatment ☐ Second Opinion ☐ Patient Request

AUTHORIZATION & SIGNATURE:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release **UROLOGY ASSOCIATES OF NORTHEAST FLORIDA** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges and postage related to the production of my information. *For patients and government entities*: $1.00 per page for the first 25 pages and $0.25 per page for each page in excess of the first 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: ______________________ Date: ______________

Patient Signature: ______________________ Social Security # (LAST 4) ________

Printed Name of Parent, Guardian or Legal Representative: ______________________

Parent, Guardian or Legal Representative Signature: ____________ - ______________

Relationship to Patient: ______________________ **Records are needed by**: __________(date)

PLEASE SEND RECORDS BY FAX: (904) 264-9692