AUTHORIZATION TO RELEASE MEDICAL RECORDS
HIPAA RELEASE

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____

PLEASE FILL IN THE BOXES BELOW. ANY OMISSIONS COULD RESULT IN DELAYS. PLEASE ALLOW UP TO 30 DAYS FOR PROCESSING.

☐ ***I AM REQUESTING RECORDS FROM A SIMED PROVIDER. PROVIDER NAME(S): _____***

☐ ***I AM REQUESTING RECORDS FROM A SIMED DIVISION (CHECK ALL THAT APPLY):***

☐ ALLERGY & ASTHMA	☐ ARTHRITIS CENTER	☐ COMMUNITY PHARMACY	☐ FIRST CARE URGENT CARE
☐ HAND SURGERY	☐ HEALTH PSYCHOLOGY	☐ INTERVENTIONAL PAIN MGMT.	☐ NEUROLOGY
☐ NEUROSURGERY	☐ ORTHOPAEDICS	☐ PHYSICAL THERAPY	☐ PODIATRY
☐ PRIMARY CARE	☐ PSYCHIATRY	☐ PULMONOLOGY	☐ REHABILITATION MEDICINE
☐ SLEEP CLINIC	☐ WOMEN'S HEALTH	☐ UROLOGY	

☐ ***I AM REQUESTING RECORDS FROM A PROVIDER OR FACILITY OUTSIDE OF SIMED***

NAME OF PHYSICIAN/FACILITY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

SPECIFIC ITEMS TO BE RELEASED (*check all that apply*):

☐ Office Notes/Demographics	☐ History & Physical	☐ Allergy Test Results	☐ Radiological Reports / Images
☐ EMG/NCS Reports	☐ Cardiovascular Report	☐ Laboratory/Pathology Reports	☐ Pharmacy / Prescription Info
☐ Hospital_____	☐ Operative Reports	☐ Financial Information	☐ Other: _____

EXTREMELY CONFIDENTIAL MATERIALS *(check all that apply)*:

☐ HIV/AIDS ☐ Alcohol / Drug Abuse ☐ Psychiatric / Psychotherapeutic ☐ Sexually Transmitted Disease

I AM REQUESTING RECORDS FOR TREATMENT DATES _____ TO _____

PLEASE SEND MY RECORDS TO (NAME OF PERSON OR PROVIDER) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

☐ ***INDIVIDUAL RELEASE: I PERMIT SIMED to discuss or review my personal health information, as indicated above, with the following individual(s):***

_____ _____
Print Name Print Name

_____ _____
Relationship to Patient Relationship to Patient

☐ ***I REVOKE approval for my personal health information to be released to the above listed individual(s) or entity.***

By signing below, I understand that: 1) This authority is good for one year from the date listed. 2) I am under no obligation to sign this authorization and that my ability to obtain treatment, eligibility for benefits, etc… will not depend in any way on whether I sign this authorization. 3) I have the right to inspect obtain a copy of any information disclosed pursuant to this authorization. 4) I may be charged a fee for these records as allowed by Florida Law. 5) I release the above entity or Southeastern Integrated Medical, PL (SIMED) and its employees from all liability that may arise from the release of this information. 6) State law prohibits re-disclosure of the information disclosed to the person/entities listed above without my further authorization. 7) SIMED cannot guarantee the recipient of the information will not re-disclose information contrary to such prohibition. 8) I may revoke this authorization at any time by signing the revocation section of this form and remitting it to my provider. 9) Any revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this information.

_____ _____
Signature of Patient/Legal Guardian Date