AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT'S NAME (PRINT): _____ DATE OF BIRTH: _____

LEGAL GUARDIAN OR REPRESENTATIVE NAME (IF NOT PATIENT): _____

LEGAL RELATIONSHIP TO PATIENT: _____ PHONE NUMBER: _____

Please fill in the requested information below; omissions may result in delays. Allow up to 30 days for processing.

I am requesting records FROM SIMEDHEALTH (Check all that apply)

❑ **ALL SIMEDHEALTH RECORDS FROM ALL PROVIDERS**

❑ Addiction Medicine	❑ Allergy & Asthma	❑ Arthritis Center	❑ First Care Urgent Care
❑ Hand Surgery	❑ Health Psychology	❑ Interventional Pain Mgmt.	❑ Neurology
❑ Physical Therapy	❑ Podiatry (Foot & Ankle)	❑ Primary Care	❑ Psychiatry
❑ Pulmonology	❑ Rehabilitation Medicine	❑ Sleep Clinic / Sleep Lab	❑ Spine & Neurosurgery
❑ Women's Health	❑ Urology	❑ Other_____	

Specific Information (Check all that apply)

❑ Appointment Information	❑ Demographic Information	❑ Financial Information	❑ Hospital & Operative Notes
❑ Medication / Prescription	❑ Office Notes	❑ Referral Information	

❑ Reports/Images/Test Results: ❑ Lab ❑ Radiology ❑ Diagnostic ❑ Other: _____

SEND MY SIMEDHEALTH RECORDS TO (NAME): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

I am requesting records FROM A PROVIDER OR FACILITY OUTSIDE OF SIMEDHEALTH

NAME OF PHYSICIAN/FACILITY: _____

ADDRESS: _____

PHONE: _____ FAX: _____

❑ ALL RECORDS ❑ OTHER: _____ TREATMENT DATES: _____ TO: _____

PLEASE SEND MY RECORDS TO MY SIMEDHEALTH PROVIDER:

❑ SIMEDHealth Medical Records
4343 Newberry Road, Suite 18
Gainesville, FL 32607
Phone: (352) 224-2251 Fax: (352) 224-7019
For Gainesville, Chiefland, High Springs office locations

❑ SIMEDHealth Medical Records
3304 SW 34th Circle, Suite 104
Ocala, FL 34474
Phone: (352) 372-1504 Fax: (352) 732-0028
For Ocala, Lady Lake / The Villages office locations.

THE FOLLOWING ARE CONSIDERED EXTREMELY CONFIDENTIAL PROTECTED HEALTH INFORMATION AND WILL NOT BE RELEASED WITHOUT YOUR AUTHORIZATION. *(CHECK ALL THAT APPLY)*

❑ Sexually Transmitted Disease ❑ Alcohol/Drug Abuse Records ❑ Psychiatric / Psychotherapeutic ❑ HIV/AIDS

By signing below, I understand that:

- The purpose of this disclosure is at the request of the individual listed above.
- This authority is good **for one year from the date listed**.
- 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.
- I have the right to inspect or obtain a copy of any information disclosed pursuant to this authorization.
- I release the above entity or SIMEDHealth and its employees from all liability that may arise from the release of this information.
- The law prohibits re-disclosure of the information disclosed to the person/entities listed above without my further authorization.
- SIMEDHealth cannot guarantee the recipient of the information will not redisclose information contrary to such prohibition.
- I may revoke this authorization at any time by providing a revocation in writing and remitting it to my provider (unless excepted by law).
- Any revocation does not apply to the extent that the person authorized to use or disclose my health information has already acted in reliance on this information.
- I may be charged a fee for these records as allowed by Florida Law.

_____ _____

Signature of Patient/Legal Guardian or Representative Date

Last Updated: 1/15/2025