Niceville Family Practice

Medical Records Release

Authorization Release for Use and Disclosure of Protected Health Information

Patient Legal Name	Date of Birth	Social Security Number

Address	Telephone Number

City	State	Zip

I hereby authorize ____

Practice Name or Physician Name Telephone Number

to disclose medical record information and/or protected health information of the patient listed above to:

Niceville Family Practice

4400 Hwy 20 East, Suite 203

Niceville, FL 32578

Phone: 850-897-3678 Fax: 850-897-3708

Purpose: ____

Records Requested:
(check records that apply)

Entire Record	Rehabilitation Services	Nursing Notes
History & Physical	Labs	Progress Notes
Consultation Reports	Radiology	Medication List
Emergency Room	Demographics	Physician Orders

***This authorization shall expire upon fulfillment of this request**
(according to HIPAA or State Regulations, whichever is shorter)*

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing/results or AIDS information. __________Initial If not applicable, check here. ___________
I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
Fees/Charges will comply with all the laws and regulations applicable to the release of information.
I have read the above statement and authorize the disclosure of the protected health information as stated.

____ ______________________
Signature of Patient/Guardian Patient Representative: **Date:**

____ ______________________
Print Name of Patient's Representative: **Relationship to Patient:**