MAIN STREET MEDICAL CENTER

369 N. Main Street Crestview, FL, 32536 · Office (850) 398-6963 · Fax (850) 398-8277

Authorization to use/disclose health information "MEDICAL RECORDS RELEASE"

Patient Name: _____ Date of Birth: _____

Address: _____ Contact #: _____

Release Medical Records FROM:	**Disclose Medical Records TO:**
Facility Name: _____ Physician: _____ Address: _____ City, State, Zip: _____ Phone:_____ Fax:_____	Main Street Medical Center 369 N. Main Street Crestview, FL 32536 PROVIDER: ☐ Joshua K. Kolmetz, M.D. ☐ Jonathan Aspinwall, APRN ☐ Lindsay Adams, APRN ☐ Adam Crowson, APRN

	INFORMATION TO BE DISCLOSED
☐ **EXPIRATION DATE** _____ ☐ Lifetime Medical Release while under the care of Main Street Medical Center and its associated providers. **Purpose of Disclosure:** ☐ Continuing care with another provider or facility ☐ Other _____	☐ Inpatient Records ☐ Physician Records ☐ Entire Medical Record ☐ Labs, Imaging or Pathology

Authorization:

1. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include ***alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnosis*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.
2. I may revoke this authorization at any time by notifying the "SENT FROM" organization in writing.
3. I understand that my revocation does not affect any disclosure made prior to the revocation being processed.
4. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
5. I have the right to inspect or copy the information to be used/disclosed by federal law.
6. I may refuse to sign this authorization.
7. I am eligible to receive a copy of this form after it is signed.

Patient/Guardian Signature_____ Date _____

Printed Name_____ Relationship to Patient_____

Witness Signature_____ Date_____

NOTICE TO RECEIVING PARTY: This information is to be treated in accordance with Health Information Portability and Accountability Act (HIPAA) privacy regulations.