EXPRESS CARE
Of Ocala
The ER Alternative

1834 SW 1st Ave, Ste 201 Ocala, FL 34471

Phone: 352-732-9888 Fax: 352-732-0490

Medical Release Authorization

Patient Name: _____ DOB: _____

I hereby authorize and request _____to release medical information concerning my medical care to Express Care of Ocala, for the purpose of:

_____

(Specific purpose of disclosure of record)

The type and amount of information to be disclosed is as follows: (Specify dates where appropriate)

_____Last 3 Progress Notes

_____Most Recent Laboratory Tests

_____Bone Density

_____Most Recent Radio-Diagnostics Test

_____Problem List / Medication List

_____Other

_____Recent Colonoscopy

_____Eye Exam

_____Mammogram

_____ALL Records

I understand that the information may include the release of information concerning HIV testing or treatments of AIDS or AIDS related conditions, drug or alcohol abuse (or related conditions), and mental health conditions.

I understand the use or disclosure of my individual health information, as described above. I understand that this authorization will expire, without my express revocation, either one (1) year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. I understand that this authorization is revocable, upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation, and that is may be re-disclosed by the recipient.

The facility, its employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.

_____ _____

Patient Signature Date