Dixie County Emergency Services
Medical Records Request Form

Authorization To Disclose Protected Health Information

RELEASE INFORMATION FROM DISCLOSE INFORMATION TO

Self: ______________________________________
Other: ______________________________________
____

PURPOSE OF DISCLOSURE
Personal - **I understand that** I may be charged for copies of this information in accordance with Florida Law. ($1.00 per page for the first 25 pages/copies and $0.25 for each additional page)

INFORMATION TO BE DISCLOSED (Specify service date______________________________)

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

____
____
Patient's Full Name Patient's Social Security Number/Medical Record Number
____
____
Address Patient's Date of Birth
____
____
City/State/Zip Patient's Phone Number

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified_________________ .

I understand that once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Medical Records Custodian at P O Box 2009 Cross City, FL 32628.

I understand that Dixie County Emergency Services will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

X -- ----------------------------------
Signature of Patient or Patient's Representative Relationship (if not patient)* *Date*
*If a personal representative of the patient signs the authorization, please indicate his or her authority to act.

Official Use Only

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