Florida Digestive Health Specialists

**MEDICAL RECORD RELEASE**

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient First Name _____ Date of Birth _____

Patient Last Name _____

Recipient ☐ Hospital ☐ Physician ☐ Patient ☐ Other_____

Method ☐ Email ☐ Fax ☐ Mail ☐ Patient Portal ☐ Pick-up (Pick up date _____)

☐ Release ALL Records
☐ Release only the records from the period between _____ and _____

Recipient contact information (complete all applicable information)

Name _____

*Address _____

Phone _____ *Fax _____

*Email _____

Requestor information (if not the patient) Relationship to patient _____

Name _____

Requestor's Signature _____ Date _____

Under Federal law, a patient may request a copy of her medical records. A fee may be charged for this service in accordance with State law. FDHS follows Florida Rule 6488-10.003 regarding charges for medical records. The cost shall be $1.00 per page for the first 25 pages. For pages in excess of 25, the cost shall be 25 cents each. Other fees may apply to records exceeding 100 pages delivered in PDF format.

I authorize Florida Digestive Health Specialists (FDHS) to use, disclose/dispense my health information to the person(s) or organization listed above. I understand this authorization is valid for 60 days. I understand that I can revoke this Authorization at any time. I understand that the revocation will not apply to information already released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. Further, I acknowledge that the fees incurred by producing a copy of my medical records are my responsibility and will be applied to my account. Payment is due at the time of pickup.

*Patient Signature _____ Date _____

**If the patient is a minor (under 18), this form must be signed by a parent or legal guardian.*

Please fax this completed form and a copy of the requester's photo ID to your providers office. If records are picked up at the provider's office, a photo ID will be required at the time of pick-up.

*Office use only:*

*MR#*_____ *Received Date* _____ *Processed Date* _____

*Processed by*_____