1501 N US Hwy 441 Suite 1704, The Villages, FL 32159
Phone: 352-750-4333 | Fax: 352-750-2023

Records Release Authorization

I, ___________________________________, (print clearly) specifically authorize **HealthCare Partners Family Medicine** to request my protected health information from the specialist or medical practice named below for the purposes of treatment and health care operations.

Description of the information to be used or disclosed (*check all that apply*):

[ ] Any and all Records* [ ] Diagnostic Reports Only [ ] Lab Results Only [ ] Immunizations
[ ] Chart Notes Only [ ] Consultations Only [ ] Other ____________________

*May not include mental health treatment records, psychological services and social services information, including communications made by patient to a social worker or psychologist.
*May not include communicable disease and infection information (which include venereal disease “VD”, tuberculosis “TB”, Hepatitis B, human immunodeficiency virus “HIV”, acquired immunodeficiency syndrome “AIDS”, and AIDS related complex “ARC”).
*May not include alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

Name of the specialist or other medical practice, address, and fax number:

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HealthCare Partners Family Medicine shall send information ONLY to the above address and /or fax number. Any disclosure of the patient’s protected health information to another address or fax number will require a separate authorization.

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. For the revocation of this authorization to be effective, **HealthCare Partners Family Medicine** must receive the revocation in writing with my signature.

This authorization shall expire on ______________________. After this date, **HealthCare Partners Family Medicine** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If date left blank, this is a lifetime authorization for release of information.

I fully understand and accept the terms of this authorization.

__________________________ ____________________________
Patient's Signature Date