Medical Records Department
1401 Centerville Road Suite 300
Tallahassee, FL 32308
Phone 850-558-1289
Fax 850-558-1282

HIPAA Authorization to Use and Disclose Health Information

The charge for records printed is $1.00 per page for the first 25 pages and $.25 per page thereafter or you may request your records <u>electronically</u> for $10.00 per request.

Patient's Last Name_________________________ Patient's First Name _______________________

Patient's DOB_____________ Patient's SSN ____________________________

Please Check All That Apply:

☐Complete copy of all records, as allowed by law. ☐Billing Report

☐Office Notes ☐Surgery Report ☐MRI/X Ray Reports

☐ Mental Illness or Developmental Disability ☐ HIV/AIDS testing or treatment ☐Child Abuse and Neglect

☐Substance Abuse ☐Sexual Assault ☐Sexually Transmitted Diseases (STD's)

☐Other Specific Section of Records (please specify) ____________________________________

Authorization Valid For:

☐This request only.

☐One year from the date of this authorization OR ____/____/_____(insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

Please mail the records listed above to:

____

________________________________ Or Fax To: (____)_________________

____

Signature of Patient or Patient's Representative:______________________________

Relationship to Patient: __________________

Date:________________