Medical Records Department
1401 Centerville Road Suite 300
Tallahassee, FL 32308
Phone 850-558-1275
Fax 850-558-1282

HIPAA Authorization to Use and Disclose Health Information

CHARGE FOR RECORDS

PRINTED COPY- $1.00 per page for the first 25 pages & $.25 per page thereafter.
ELECTRONICALLY (thumb drive) - flat fee of $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: _____