5101 Brittany Drive South Saint Petersburg, FL 33715 Phone: (727) 954-7204 Fax: (877) 215-9813

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Last Name: _____ First Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

The above listed patient hereby authorizes the following doctor/healthcare facility to release any/all medical records, and protected health information to Prawer Medical Group for the purposes of continuation of care:

Doctor/Facility Name: _____ Phone: _____

Doctor/Facility Address: _____ Fax: _____

Doctor/Facility City, State, Zip Code: _____

Dates and Type of Information to Disclose:

☐ 2 Years Prior From Last Date Seen
☐ Specific Dates: From _____ To _____
☐ Specific Information Requested: _____
_____

The Purpose of The Disclosure:

☐ Change of Insurance or Physician
☐ Continuation of Care (VA Med Ctr, etc)
☐ Referral
☐ Other: _____

☒ **PLEASE MAIL RECORDS to PRAWER MEDICAL GROUP** ☐ **PLEASE FAX RECORDS to (877) 215-9813**

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or HIV/AIDS test results. I expressly consent to the release of information as designated above.

I understand that I may revoke this authorization at any time. I further understand that this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing this disclosure is voluntary, and that I need not sign this form, in order to assure treatment. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this form, there is a processing period of 7-14 business days.

Patient/Parent/Guardian Signature: _____ Date: _____
(or Authorized Representative)

Printed Name of Guardian/Authorized Representative: _____

Relationship / Capacity to Patient: _____ Phone: _____