Authorization for the Request of Patient Health Information
From Outside Health Care Providers

Please Print Cleary
Patient Name: ____ **Date:** ________________
Date of Birth: ______________________ **Address**: ______________________________________
Patient Phone Number: _____________________________

I, ___________________________, **hereby request and authorize the release of the following records from:**

____
(Facility/Physician PHI requested from) (Phone Number) (Fax Number)

____
(Street Address) (City) (State) (Zip Code)

REQUESTED INFORMATION:

___MRI Reports **___OP Report** **___Consultation** **___Diagnostic/Lab Results & Reports (Complete)**

___MRI Films **___Discharge Summary** **___Pathology**

___X-Ray Reports **___Office Notes (Complete)** **___Cardiology**

___X-Ray Films **___EMGs** **___Complete Medical Record**

Other:
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This release of information is for continuity of care, unless otherwise noted:
____

My Records may contain the following and, **unless crossed out and initialed**, I specifically authorize their release:
HIV Test Results (Test for AIDS) **AIDS Related Records** **Drug or Alcohol Records** **Tuberculosis Records**
STD Records (Sexually Transmitted Diseases) **Mental Health Records** **Pregnancy Records**

TO:
Name of Provider/ Facility: Lynn Kettell-Slifer, Health Partners, LLC.
Address: 130 Corridor Road, Box 830 Ponte Vedra Beach, FL 32004

Phone Number: (904) 373-0942
Fax Number: (904) 395-9018

Patient or Authorized Signature: ____________________________________**Date:** _____________________
Relationship to Patient:
____
(Explain and/or attach legal document)

Pursuant to Florida law and the Health Insurance Portability Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida Law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may

revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another date is written here ________________________.

****PLEASE FAX THE LAST OFFICE NOTE ASAP, AS THIS IS FOR IMMEDIATE PATIENT CARE. THANK YOU. FAX (904) 395-9018**