Palms Medical Group
Your home for health, wellness, life
911 S Main Street
Trenton, FL 32693
352-463-2374 – phone
352-463-2726 - fax

Medical Record
Release Authorization

Date

Name (Last, first, middle initial) | Patient Date of Birth

Street address, City, ST, ZIP Code

Primary phone number | Cell phone number | Email address

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

A) I hereby authorize records FROM:

Name: _____

Address:_____

City/State/Zip:_____

Phone: _____Fax:_____

B) To be released TO:

Name:_____

Address:_____

City/State/Zip:_____

Phone: _____Fax:_____

C) For the purpose of:

___ Continuity of Care
___ Litigation
___ Insurance
___ Self/Personal Copy
____ Disability/SSI
____Workers Comp
____ Other
____ Transfer of Care (permanently leaving PMG)

What:

❑ Last 2 Office Notes
❑ Immunizations
❑ Operative/Procedure Reports
❑ Other_____
❑ Last Cardiology/EKG Reports
❑ Last 2 Lab/Path Reports
❑ Last Radiology/X-ray MRI Reports
❑ Minimum Necessary

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving writing notice to the person or organization named above in Section B.

In Addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that the information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that there are some circumstances in which this information may be re-disclosed to other persons.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- **I have read all of this form and agree to the disclosures above from the types of sources listed.**

X

Signature of Patient or Patient's Legal Representative**** Subject to Fees** | Date Signed

Print Name of Legal Representative (If applicable)

Indicate: ❑ Parent of Minor, ❑ Guardian, ❑ other personal representative (explain):_____

Board Approved March 17, 2016