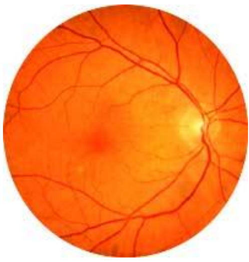

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## MEDICAL HEALTH RECORD RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the person(s) or entity listed below. Limitations on the information you may release subject to this Release Form are as follows:

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Patient Name: ________________________________________ Patient Date of Birth: ____________________________

Patient SS# (last 2 digits only): ________________ Patient Contact Number: ___________________________________

Doctor or Facility to release records:______________________________________________________________________

**Release my protected health information to the following person(s)/entity:**

Name:____________________________________________ Contact Number: __________________________________

DATES OF SERVICE:________________________________________________________________________________

Address:___________________________________________________________________________________________
City State Zip

**I understand** that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. **I understand** that I have the right to revoke this authorization at any time in writing and present it to the organization releasing the information. **I understand** that the revocation will not apply to my insurance company or other providers who are participating in my healthcare treatments. **Unless an expiration date is specified, this authorization will expire is 6 months from the date of request.**

**I understand** that authorizing this disclosure of health information is voluntary. **I understand** that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Privacy Officer for Charles A. Garcia, M.D., P.A..

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT**: I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information. I will not hold Charles A. Garcia, MD, P.A. or my provider(s) liable for any misinterpretation of the information in my medical record as a result of not consulting with my physician for the correct interpretation. **Initial:** __________ **Date:** ____________________

_______________________________________ _______________________________________
Printed name of patient or legal guardian Signature of patient or legal guardian

_______________________________________ _______________________________________
**Relationship to patient (if legal guardian)** **Date**