AUTHORIZATION FOR RELEASE OF INFORMATION

Calvin L Blount Jr MD
12607 US Hwy 98 West
Miramar Beach, FL 32550
850.837.4844 phone 850.837.6625 fax

Patient Name: _____ **Date of Birth**_____

Address:_____

City/State/Zip:_____**Telephone**_____

I authorize the release of medical information as indicated below:

FROM:

Practice Name:_____

Address:_____

TO:

Name:_____

Address: Please fax to 850.837.6625

☐ I would like to pick up my records: please call me at _____ ☐ I would like to records mailed (please indicate address above)

What to Release: Please choose the records you would like released:

☐ Outpatient notes
☐ X-Ray report(s)
☐ Pathology Report(s)
☐ Other Specify_____
☐ Laboratory reports
☐ X-ray Film(s)
☐ Immunization record
☐ All medical records

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests ☐ Yes ☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders ☐ Yes ☐ No/NA

Purpose of the release: Please indicate the reason for this release

☐ For another doctor
☐ Use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ To obtain disability
☐ Worker's care
☐ Armed forces requirement
☐ Other _____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for _____days.

I understand this Authorization can be revoked at any time according the [practice name's] privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by [Practice name] and may potentially be re-disclosed by the party who received these records. [Practice name], its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of the patient Date

_____ _____
Signature of legal representative and relationship to patient Date

_____ _____
Signature of witness Date

Form 10ARI