Request will not be processed unless form is completed in its entirety.

SHIELD MEDICAL GROUP **Release of Information**

6801 US Highway 27N Suite D2 Sebring, FL 33870 • Telephone: 863-236-9550 • Fax: 877-832-3363

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE PRINT

REQUEST MEDICAL RECORDS FROM: List Physicians/Providers	**DISCLOSE INFORMATION TO:**
_____	_____
_____	_____
_____	_____
_____	**Physician Appointment Elsewhere** _____ (DATE **and** TIME)

IDENTIFYING INFORMATION

_____ **PATIENT'S FULL NAME**

_____ **PATIENT'S SOCIAL SECURITY NUMBER / MEDICAL RECORD NUMBER**

_____ **ADDRESS**

_____ **PATIENTS DATE OF BIRTH**

_____ **CITY/STATE/ZIP**

_____ **PATIENT'S PHONE NUMBER**

PURPOSE OF DISCLOSURE ❑ Personal

❑ Continued Care

❑ Other: _____

Please check the following health information items to be released with a beginning date of _____ **through** _____

❑ Office Visits ❑ Pathology Reports ❑ Lab Reports ❑ Immunizations **Radiology:** ❑ Reports ❑ Copy via CD

I understand that I may be charged for copies of this information in accordance with Florida Law.

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified _____

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Records Custodian, Shield Medical Group Sebring, 6801 US Hwy 27 N Ste D2 Florida 33870.

I understand that Shield Medical Group will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. **I understand the** matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

X

_____ _____ _____

Signature of Patient or Patient's Representative* Relationship (if not patient) Date

**If a personal representative of the patient signs the authorization, please indicate his or her authority to act.*

OFFICIAL USE ONLY	
Date Received Date Completed	
Processed by	# of Pages