1424 US HWY 331
DeFuniak Springs, FL
32435
P (850)920-1700
F (850)520-5357

MEDICAL RELEASE CONSENT **(Complete all sections to prevent delays. Allow you to 14 business days for request to be processed.)**

Patient Legal Name: ______________________ Birth Date: ______________ XXX-XX-__________ Social Security No.

Patient Address ______________________ Telephone No. ______________

City ______________ State ______ Zip Code ______________

For Disclosure Only
I hereby authorize ______________________________
Name of Physician and/or Practice Name to Release Records

Fax Number ______________ Telephone Number ______________

To disclose medical record information and/or protected health information of the patient listed above to:

DEFUNIAK ALL-CARE
Michael Jeter APRN/Tommy Simmons APRN
1424 S. US 331
DEFUNIAK SPRINGS, FL 32435
PHONE: (850) 920-1700
FAX: (850) 520-5357

Purpose: ______________________________

Type of Access:

- ☐ Copies of the record
- ☐ Entire Record
- ☐ Emergency Room

Select Portions of Personal Health Information:

- ☐ History & Physical
- ☐ Consult Report
- ☐ Operative Report
- ☐ Lab
- ☐ Imaging / Radiology
- ☐ Demographics
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Path Report
- ☐ Physician Order
- ☐ Billing Records
- ☐ Other ______________

Expiration: This authorization shall expire in one year unless otherwise specified below:

- ☐ Fulfillment of the request (according to HIPAA or State Regulations, whichever is shorter)
- ☐ Date ______________________ (Not to exceed one year)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information is used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. Fees/changes will comply with all laws and regulations applicable to release of information. Power of Attorney (POA) must be attached if signing as POA.

Date ______________ Signature of Patient/Responsible Party ______________________ Relationship to Patient ______________

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Address and telephone number of Requestor (if different from patient information)