Email: medicalrecordsrequests@rccsma.com

Phone 904-253-6910 Fax 904-253-6964

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____
Home Phone: _____ Cell Phone:_____
Address:_____ City/State/Zip:_____

PLEASE NOTE: A COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

- **This information may be disclosed and used by the following individual or organization**

Release To:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax:_____

- **Above listed patient authorizes the following healthcare facility to make records disclosure:**

Facility Name:_____
Facility Address:_____ Facility Phone:_____
City/State/Zip:_____ Facility Fax:_____

- Complete Records
- Billing Records
- Progress Notes
- Medication Records
- Radiology Reports
- Lab Reports
- Sleep Studies

Other:_____

Restriction: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated on this authorization.

I understand the information in my health records may include information relating to human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and understand that the revocation will not apply to information that has already been released in response to this authorization.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date:_____
Patient/Legal Guardian Signature

X_____ _____
Printed Name of Patient/Legal Guardian Relationship to Patient