Authorization to Disclose Protected Health Information

Magnolia Medical Clinic
131 Magnolia Avenue SE
Fort Walton Beach, FL 32548
Phone (850) 243-7681
Fax (850) 243-0471

I provide the undersigned authorizes to release my health information as noted below:

❑ Dr. Bill Buckelew ❑ Dr. Chris Pappas
❑ Dr. Peter Senechal ❑ Dr. John Sites

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ **Date of Birth:** _____

City: _____ State: _____ Zip: _____ Phone #: _____

Email: _____ *(Patient's Only – Please ensure email address is legible!)*

Release Information From / To *(circle one)*

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Please forward Records by: ☐ Mail ☐ Fax (for Dr's Offices) ☐ Email (For Patients)

Information to be Released ***If you fail to specify, a 1 year abstract will be provided.***

☐ Please release a **1 year** abstract of my records (includes most recent notes, labs, & testing)
☐ Please release a **2 year** abstract of my records
☐ Please release my **entire record**.
☐ **Other** (please specify): _____
_____

Records being requested or sent to another healthcare provider will be provided at no cost.
I understand I will be responsible for the charges incurred in the release of my protected health information. *See FL Statute 64B8-10.003*
Copy fee: $1.00 per page for the first 25 pages
$0.25 per page, thereafter.
Postage, if applicable
Please remember, your records may be available on our patient portal for FREE! https://mmcfp.portalforpatients.com

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial*)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*