Authorization to Disclose Protected Health Information

Magnolia Medical Clinic
319 Green Acres Rd Suite 101
Fort Walton Beach, FL 32547
Phone (850) 243-7681
Fax (850) 243-0471

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

Dr. Pappas Dr. Skojac Dr. Paulson Dr. Zachary Dr. McDevitt
Dr. Loudermilk

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

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.

** 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.*

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