Magnolia Medical Clinic
Family Medicine

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

Authorization For Use or Disclosure of Protected Health Information

Please complete this form in its entirety. Items not checked or unfilled blanks are assumed to be non-applicable.
This release is not valid unless signed and dated by the patient or legally authorized representative.

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

Name/Facility: _____ Address: _____

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

Fax #: _____ Purpose of Request: □ Personal □ Treatment □ Legal

□ Insurance □ Transfer of Care □ Other: _____

Release Information To

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

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

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them. Once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Information to be Released

□ Disclose my complete health record, including, but not limited to, reproductive health care information, medical history and physical results, progress notes, diagnoses, lab test results, treatment, and billing records for all conditions. **I specifically authorize the release of information relating to sexually transmitted infection(s) (STI) and/or HIV/AIDS testing, diagnosis and treatment, genetic information, psychiatric and psychological/mental health records (not including psychotherapy notes), alcohol/substance misuse disorder records.**

□ Disclose my complete health record except I do not authorize disclosure of the following information:

- □ Sexually transmitted infection (STI) testing, diagnosis, and treatment
- □ HIV and AIDS testing, diagnosis, and treatment
- □ Genetic information
- □ Alcohol/substance misuse disorder treatment records

□ **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.
Additional Postage fee, if applicable.

Please remember, your records may be available on our patient portal.

https://mmcfp.portalforpatients.com

Magnolia Medical Clinic
Family Medicine

Authorization For Use or Disclosure of Protected Health Information

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

Method of Disclosure

I authorize disclosure by the following methods: (check all that apply)

- □ Electronic copy (via email)
- □ Hard/Paper copy
- □ Fax

Expiration and Revocation

This authorization will expire (insert date or event) _____.

I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it is signed.

Please initial to indicate your understanding:

____ I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing to the disclosing Facility.

____ I understand that the revocation will not apply to information that has already been released in response to this authorization.

To revoke Magnolia Medical Clinic's authorization to disclose records, you should use the following contact:

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

Authorization For Use or Disclosure of Protected Health Information

Please initial:

____ I understand that Magnolia Medical Clinic or the Disclosing Entity cannot condition treatment upon my signing this authorization.

I understand the matters discussed on this form and I authorize disclosure and use of information as described in this form.

Signature: _____ Date: _____

Printed Name: _____

If this form is being completed by a person other than the patient, please describe below how this person has legal authority to sign this form (such as a parent or legal guardian of a minor or health care agent):

_____

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.