Authorization for Release of Medical Information

Family Medical Care of Riverview, P.A.
7229 US HWY 301 South
Riverview, FL 33569
813-677-8418 / 813-864-8018 (fax)

I, the undersigned, hereby authorize the release of any and all medical information and records, or as described below on:

Patient Name: ______________________________

Birth Date: ______________________________

Social Security Number: ______________________________

Reason:
☐ Patient **Requesting** Medical Records from Other Practice.
☐ Chart Copies for Other Reasons (___________________)
☐ Patient **Transferring** Out of Practice/FAXING RECORDS
{There will be a $15 Transfer Fee for ALL RECORDS (FAXED) or a charge of $1 per page, whichever is lowest}=This DOES NOT apply to patient's picking up medical record copies.

*****I request that Family Medical Care of Riverview, PA release a copy of my medical records created by this office to the physician listed below. This authorization is valid thru ______/________/_________(Month/Day/Year). I understand that I may revoke this consent in writing except to that the extent that the practice has already made disclosures in reliance upon my prior consent.*****

☐ **Send To:** ☐ ***Release From:*******	☐ *******Send To:*** ☐ **Release From:**
Family Medical Care of Riverview, P.A. 7229 US HWY 301 South Riverview, FL 33569 813-677-8418 / 813-864-8018 (fax)	______________________________ ______________________________ ______________________________

*This authorization is to ☐ **include** or ☐ **exclude** psychiatric records, drug and alcohol abuse records, and AIDS testing results.*

Date(s) of Service: **(Last 3 years)** ______________ ☐ *All Dates of Service*

☐ **Entire Record**
☐ Copy of Patient's Bill
☐ Cardiology Reports
☐ Other as Specified: ______________________________
☐ Progress Reports / Physician Notes
☐ Radiology Reports
☐ Lab / Pathology Reports

Signatures:
Patient: ______________________________
Legal Guardian: ______________________________
Date: ______________________________

Our Notice of Privacy Practice provides information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to Access, Inspect, and Copy protected health care information used to make decisions about them. The Practice will only include information used to make decisions about the patient. The Practice will limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold requested information.

Copy Fees: Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the request.

Initial Research/Storage Fee $15.00:	$
Pages 1 – 25 (___ x $1.00 Each):	$
Pages 26 & Up (___ x $.25 Each):	$
Postage:	$
Total Cost *:	$

** Medical Records Fees based on Florida Statues 458.309 FS (455.241, 455.242, & 458.331) amended 5-12-88. Health care providers and facilities may charge for providing copies of medical records:*

- *Initial Research Fee of $15.00*
- *$1.00 per page up to 25 pages*
- *$.25 per page above 25 pages*
- *Actual Postage*

Please make checks payable to: Family Medical Care of Riverview, P.A.