MANGROVE MEDICAL GROUP

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Patient Name_____ DOB_____ Ph_____

REQUESTING RECORDS FROM:

Name _____ Address _____

Phone/Fax _____ City, State, Zip _____

SENDING RECORDS TO:

Name _____ Address _____

Phone/Fax _____ City, State, Zip _____

The purpose for this request to release information is:

☐ continuity of care/transfer ☐ Insurance ☐ Other (specify)_____

Records to be released:

☐ All records ☐ All records for the following date(s) only_____

☐ Progress notes ☐ Labs ☐ Radiology ☐ Other (specify)_____

Expressed Authorization to release or include any sensitive/protected health information such as AIDS/HIV, STD, alcohol/drug abuse or treatment, treatment for minors, mental health records (depression, anxiety, PTSD, ADD, ADHD):

I consent for release of this information: _____ Date:_____

Please note this authorization will remain in effect for one year from date signed unless specified here _____

- Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained by me or unless such disclosure is specifically permitted or required by law. A photocopy of facsimile of this authorization shall be considered effective and as valid as the original.
- I have been advised of their right to receive a copy of this authorization.
- I may revoke this authorization at any time before the information is released by providing written revocation as specified in the Notice of Privacy Practices.
- The physician's office will inform me of charges for cost of labor, materials, or postage for records and arrange for payment.
- I understand release of information includes medical history, illness or injury, consultations, prescriptions, treatments, diagnosis, prognosis, including x-rays, correspondence and/or records that the above named provider may hold by means of mail, fax, or other electronic method.

Signature of Patient/authorized representative_____ Date_____

Witness signature_____ Identification Checked_____