Manatee Physician Alliance

Authorization for Release of Medical Records

Patient Information

Patient Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Request Authorization

☐ **I authorize my medical records to be released from:** _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____ Fax: _____

To (*please check location below*)**:**

☐ North River Family Health Center	606 4th Avenue West, Palmetto, FL 34221	941.722.7785
☐ Manatee Primary Care Associates	5225 Manatee Avenue West, Bradenton, FL 34209	941.708.8081
☐ Manatee Surgical Alliance	232 Manatee Avenue East, Bradenton, FL 34208	941.254.4957
☐ Manatee Weight Loss Center	232 Manatee Avenue East, Bradenton, FL 34208	941.896.9507
☐ Doctors of Manatee	1720 Manatee Avenue East, Bradenton, FL 34208	941.216.2878
☐ MMH Internal Medicine Residency Clinic	250 2nd Street East, Suite 4G, Bradenton, FL 34208	941.708.8199
☐ Bradenton Neurology	200 3rd Avenue West, Suite 110, Bradenton, FL 3420	941.746.3115
☐ Lakewood Ranch Medical Group	8340 Lakewood Ranch Blvd, Suite 210, Bradenton, FL 34202	941.782.2800
☐ Lakewood Ranch Primary Care – Rye Road	1854 Rye Road East, Bradenton, FL 34212	941.216.3939
☐ Manatee Urgent Care	☐ 4647 Manatee Avenue West, Bradenton, FL 34209	941.745.5999
	☐ 9908 State Road 64 East, Bradenton, FL 34212	941-747-8600
	☐ 6272 Lake Osprey Drive, Sarasota, FL 34240	941-907-2800

☐ **Send my medical records to:** _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____ Fax: _____

Information to be Released

☐ Complete Health Record from: (date) _____ to (date) _____ ☐ Test results, specific test _____

☐ Other, please specify exact information _____

☐ Mental Health/Substance Abuse/HIV related information.

- Patient signature required _____ Date: _____

Purpose of Release

☐ Continuing Care ☐ Insurance Claim ☐ Disability Determination ☐ Other (Please describe)

☐ Transfer of Care ☐ Personal Copy ☐ Legal Claim _____

Authorization Signatures

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization maybe subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment of my health care.

_____ _____ _____

Patient or Legal Representative Signature | Please PRINT name | Today's Date

As Legal Representative, my relationship to the patient is _____. Any document proving such authority MUST be attached.
The patient is unable to sign because _____.

Cost of Reproducing Medical Records

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.
2. Reasonable cost of reproducing copies of written or typed documents or reports shall not be more than the following:
   a. For the first 25 pages, the cost shall be $1.00 per page.
   b. For each page in excess of 25 pages, the cost shall be .25 cents.
3. Reasonable costs of reproducing x-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

Credit(s): Specific Authority 458.309 FS. Law Implemented 455.674, 455.677, 458.331 (1) Fs. History – New 11/17/87, Amended 5/12/88, Formerly 21 M-23.003, 64 f6-26.003, 59r-1 0.003.