community health centers

Community Health Centers, Inc.
(407) 905-8827 (352) 314-7400
WWW.CHCFL.ORG
Fax: (321) 221-2048

Authorization to Disclose Health Information

I, the undersigned, authorize FL435: Community Health Centers, 110 S Woodland St, Winter Garden, FL 34787 to release my health information as noted below.

Patient Information:

Name of Patient (Type/Print)	Other Names Used	Date of Birth	Phone Number
Address	City	State	Zip

Release Information To:

Name / Facility	Attention	Phone Number	Fax Number
Address	City	State	Zip

Purpose of Request:

☐ Personal ☐ Legal ☐ Disability ☐ Other:_____
☐ Treatment ☐ Insurance ☐ Transfer/Reason:_____

Charges outlined below will be applied for all copies released directly to the patient and other entities. The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released:

Unless otherwise specified, only the following information will be released. Abstract includes most recent up to 2 years: Medical History, Progress Notes, Lab Reports, and Diagnostic Testing.

☐ Please provide a 2 year abstract of my records. *(*Patient Directive Fees Apply)*
☐ Other (please be specific): _____
**Patient Directive Fees vary based on page counts and delivery methods.*
☐ Please check here if you like your records sent electronically. Email Address:_____
☐ Please check here if you like your records sent by mail.
☐ Please check here if you like your records sent on a CD.

Payment Options:

CHECK: Please make checks payable to SHARECARE.
CREDIT CARD: Please provide an email address to have an invoice sent. If you do not have an email address, an invoice will be sent to your mailing address.

Authorization to Release Protected:

Required – Please read and complete. Check the boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical record.

CHECK ONE		INITIAL EACH
I ☐ **DO**	☐ **DO NOT** want information about ***Mental Health** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***HIV Tests & Related Information** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Sexually Transmitted Disease** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Genetic Diseases/Tests DNA** released	_____
I ☐ **DO**	☐ **DO NOT** want information about _____ released	_____

STOP Please confirm that you have put a **checkmark and initialed** all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfil this request.

Patient's Signature **Date**
(Required for all patients 18 years and older. 18 years and older for psychiatric records)

Parent of Legal Guardian Signature **Date**
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation. I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. I understand that my treatment or continued treatment by the clinic and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it. I understand that I may inspect or copy the information that is used or disclosed.