ASSOCIATES IN MEDICINE & SURGERY, LLC
8851 Boardroom Circle • Ft. Myers, FL 33919
(239) 481-7000 • (239) 481-8150 fax
Specializing in Podiatry, Family Practice, Internal Medicine, Interventional Pain Management

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE Associates in Medicine & Surgery to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it, should I desire. I understand that I may revoke this authorization at any time by giving notice in writing at the address designated on this form, but if I do, it will not affect any actions taken before receipt of my revocation.
I understand that my treatment will not be conditioned on whether I provide authorization for the requested use of disclosure except (1) if my treatment is related to research, or (2) health care services are provided solely for the purpose of creating protected health information disclosure to a third party.

Patient Name:_____ Date of Birth:_____

Person/Organization to receive the information:_____

Address:_____

Phone:_____ FAX:_____

The Following information is to be released/Disclosed:

□ Progress Notes □ Labs □ X-ray Report □ Billing/Claims Records □ MRI report

□ Nerve Conduction Report □ Ultrasound Report □ Operative Report □ Complete Medical Record

This information is to be used/disclosed for the following purpose(s) only:

_____

(No other need be stated if the request is made by the patient and the patient does not wish to state purpose)

Authorization will expire on:_____ (state date or event)

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and\or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have crossed it out and initialed it.

□ YES □ NO _____Initials

I authorize the following individual know to me to PICK UP my requested information. I understand that a proof of identification will be required upon pick up.

NAME OF AUTHORIZED INDIVIDUAL:_____ Relation:_____

_____ _____

Signature of Patient or Patient Representative **Date**

Name of Patient Representative if applicable:_____ Relation:_____