**MEDICAL ASSOCIATES OF WEST FLORIDA, LLP**
**7575 STATE ROAD 52**
**BAYONET POINT, FL 34667**
**TEL: (727) 861-9800 FAX: (727) 245-1390**

## Authorization to Use or Disclose Protected Health Information
## REQUEST FOR MEDICAL RECORDS

I, (name of patient)_____, authorize

☐ **JUDITH NOEL, MD** ☐ **SONAL PATEL, MD** ☐ **KRISHNA RAVI, MD**
☐ **NARENDRA PATEL, MD** ☐ **JOHN PIRRELLO, MD** ☐ **DANIEL TERRONE, DO**
☐ **PIERRE TOTTI, MD**

To: ☐ RELEASE MEDICAL RECORDS TO OR ☐ REQUEST MEDICAL RECORDS FROM

**Providers Name**:_____
(Please Print)
**Address**:_____
(City) (State) (Zip)
**Phone Number**:_____ **Fax #**_____

**** PLEASE SEND THE MOST RECENT <u>ONE YEAR</u> HISTORY****

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated).

☐ **Progress Notes** ☐ **X-Ray and Diagnostic Testing** ☐ **Pathology**

I authorize the above named facility to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s) I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy

- This information for which I'm authorizing disclosure will be used for the following purpose:

☐ Moving ☐ Selecting new primary care provider ☐ Specialist

**<u>FEES FOR MEDICAL RECORDS</u>**

**Fees for copying records for patient's personal use are one (1) dollar per page for the first 25 pages and .25 (25 cents) for each additional page thereafter. (Rule 64B8-10.003 of the Florida Administrative Code)**

**Initial by patient**:_____

I hereby agree with the terms provided in this Request for Medical Records form.

Signed_____ Date_____
Patient or Authorized Person, ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney

Social Security Number:xxx-xx-_____ Date of Birth:_____