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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize (organization requesting records from) ________________________________________________ and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: ______________________________________________ Date of Birth: _____________________________

- I hereby authorize the release of medical records to: **Dennis L. Fernandez, M.D., P.C.**
- Purpose of disclosure: **Continuity of Care**
- The authorization will **expire one year from the date of the signature below**.

This request and authorization applies to (choose the one that applies):

_______ All medical records

_______ Health care information relating to the following treatment, condition, or dates of treatment:

_____________________________________________________________________________________

_____________________________________________________________________________________

_______ Specific records to be released (e.g. Labs, imaging reports, other):

_____________________________________________________________________________________

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

______Substance abuse ______ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

________________________________________________ ___________________________________

Signature of Patient or Authorized Representative Date Signed

_________________________________

Relationship to Patient (if applicable)