PATIENT LABEL

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Patient phone #:** _____

I request and authorize you to release any information which may be related to treatments and examinations, including substance abuse, mental health, or communicable diseases, which may be contained in my medical records (e.g. HIV/AIDS, TB, STD) for the purpose of treatment, payment and/or healthcare operations.

Provider (who is releasing the information): Emed Multispecialty Group
Provider Address: 2624 Atlantic Blvd. Jacksonville, FL 32207
Provider Phone #: (904) 513-3240 **Provider Fax #: (904) 398-7871**

Recipients Name (who is receiving the information): _____

Address: _____

Phone #:_____ **Fax #**:_____

This request and authorization applies to:

- ☐ **ALL RECORDS**
- ☐ LAST TWO (2) OFFICE NOTES
- ☐ IMAGING (CT SCAN, MRI, X-RAY REPORTS)
- ☐ LAB AND PATHOLOGY RESULTS
- ☐ BLOOD WORK, PAP RESULTS, IMMUNIZATIONS
- ☐ EKG, ECHO, STRESS, MAMMOGRAPHY TEST RESULTS
- ☐ OFFICES NOTES PERTAINING TO OPIOID/ALCOHOL DEPENDANCY
- ☐ URINE DRUG SCREEN RESULTS
- ☐ STD TEST RESULTS
- ☐ HIV/AIDS TEST RESULTS (POSITIVE OR NEGATIVE)
- ☐ MENTAL HEALTH TREATMENT
- ☐ OTHER:

_____

_____

The purpose of releasing this information is (Ex: Continuity of care, transfer of care**):** _____

_____

Patient Signature: _____ Date: _____

This request is an exchange of health information between healthcare providers for treatment, payment, or healthcare operations, therefore a HIPPA compliant release is not required (HIPPA 164.506)

Emed Multispecialty Group
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