Florida Primary Care & Sports Med
140 Pinnacles Drive
Palm Coast, FL 32164
(386) 313-6035

Medical Records Release

Patient Information	Name:_____ Social Security Number:_____ Date of Birth:_____Phone Number: _____ Address:_____ City:_____State:_____Zip: _____
Type of Release Authorization	____I authorize MediQuick to RELEASE medical records information to: ____I authorize MediQuick to OBTAIN medical records information on me from: Name of Facility: _____ Address:_____ City:_____State:_____Zip: _____
Purpose for Request	___Continue Care ___Attorney ___Insurance Claim ____Personal Use ___Change of Insurance ___Other: _____
Information Needed (Check all that Apply)	___Laboratory Results ___X-ray Reports ___History & Physical ___Immunization Record ___Other: _____

Authorization (MANDATORY)

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 Medical Records Department. 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 unless otherwise revoked. This authorization will expire on the following date, event or condition (no longer than one year): _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFT 165,524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any question about the disclosure of my health information I can contact Florida Primary Care and ask for the Medical Records Department at (386) 313-6035.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Patients or Legal Representatives Signature:_____ Date:_____
Relationship to Patient if Signed by Representative: _____
Witness Signature:_____Date: _____