INTERNAL MEDICINE
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MEDICAL RECORDS RELEASE FORM

Patient Name: _____Acct #: _____ Date of Birth: _____/_____/_____

I hereby authorize **PHYSICIANS GROUP OF S. FL, PA** to release my medical records and/or Protected Health Information including those portions, if any, of my medical records pertaining to HIV testing diagnosis or treatment, Drug or Alcohol Abuse and treatment of Psychiatric treatment to:

Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Attorney: _____ Legal Guardian: _____

This authorization is for the listed date(s) of treatment from_____ to: _____

Please specify portion (s) of medical records requested: _____

By authorizing the release of the above-mentioned records, I understand that medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I also understand that, as regulated under the HIPPA guidelines, once records are released, the record custodian or its employees have no responsibility or liability that may arise regarding any aspect of this authorization.

Furthermore, I understand I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.

The authorization for Release of information (unless expressly revoked earlier) expires six (6) months from the date the release was signed by the patient or authorized agent.

I agree to accept responsibility for payment of the fee charged for the information requested. I understand the fees charged are allowable by Florida Law. The copying fee is waived only when photocopies are for the purpose of continuing medical care.

_____	_____	_____
Patient Signature	Patient's Printed Name	Date
_____	_____	_____
Witness Signature	Witness's Printed Name	Date