AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical Records Department: 14100 58th Street North, Clearwater FL 33760
Office: 727-824-8181 **Fax:** 727-824-8165 **Email:** EvaraRecords@EvaraHealth.org

PATIENT INFORMATION:

First Name:	Middle Initial:	Last Name:	
Date of Birth (MM/DD/YYYY):	**Phone:**	**Email:**	
Street Address:	**City:**	**State:**	**Zip:**

PURPOSE OR NEED FOR DISCLOSURE:

☐ **Patient Request** (Personal Use) ☐ **Further Medical Care** ☐ **Other:**_____

WHERE ARE YOU REQUESTING MEDICAL RECORDS FROM?

Name:	Phone:	Fax:
Mailing Address:		
Multiple Locations (List any other locations you need records from; include names only):		

WHO DO YOU WANT THE MEDICAL RECORDS SENT TO?

Name:	Phone:	Fax:
Mailing Address:	**Facility Email Address:**	

WHAT MEDICAL RECORDS ARE YOU REQUESTING?

Records for Time Period / Dates of Service: _____ / _____ / _____ through _____ / _____ / _____ **Format: MM/DD/YYYY**

☐ Abstract (Office Visit Notes, Diagnostic Results, Procedure Notes)
☐ Office Visit Notes
☐ Laboratory Results
☐ Radiology/Imaging Reports (CT, MRI, X-Ray, etc.)
☐ Procedure Notes
☐ Entire Record
☐ Other: _____

By signing this form, I acknowledge and consent to the release of my health information, which may include sensitive information such as records related to alcohol or drug use, mental health or psychiatric treatment, HIV test results, or AIDS-related information.

HOW DO YOU WANT THE MEDICAL RECORDS TO BE DELIVERED?

☐ **MyChart** (Patient Portal) ☐ **Secure Email** (Encrypted, Size Limits) ☐ **Fax** (For Medical Facilities Only)

REQUESTOR'S SIGNATURE AND AUTHORIZATION DETAILS:

Print Your Name (First, Last):	Signature:
Date/Time:	**Expiration Date, Event, or Condition** (optional):

Relationship if Not Patient: ☐Parent ☐Legal Guardian ☐Healthcare Power of Attorney, Surrogate, Proxy ☐Other: _____

WHERE TO SEND THE COMPLETED FORM:

Mail: 14100 58th Street North, Clearwater, FL 33760 **Email:** EvaraRecords@EvaraHealth.org **Medical Records Fax:** 727-824-8165

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CARE THAT EMPOWERS

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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Evara Health.

Right to Receive Copy of This Authorization: I understand that if I agree to sign this authorization, I have a right to receive a signed copy of the form.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above, who I am authorizing to use and/or disclose my information, may not condition treatment or payment based on my decision to sign this authorization.

Right to Revoke This Authorization: I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke my authorization or to receive a copy of my revocation, I may contact Evara Health. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn by written request from me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization. I understand federal and state laws permit a fee to be charged for copying of patient records, and it is up to the discretion of the above facility to collect said fee(s). *This authorization shall be valid for one (1) year unless otherwise stated or revoked through written notice to Evara Health.*

NOTICE TO RECIPIENT:

The recipient of the enclosed information is not authorized to use this patient's medical records information for any purpose other than for that stated above or to disclose any information to any other person/facility without specific written authorization from the patient to do so.

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