Authorization for Release of Medical Information

772-257-TCCH (8224)

Patient Information - **Complete all sections** Medical Chart _____ Dental Chart_____

Patient Name_____Other Names During Treatment?_____

Date of Birth _____/____/_____Address _____

City _____State _____ Zip _____Day Phone _____-_____-_____Cell Phone___-_____-_____

Purpose of Request: ☐ Personal Use ☐ Legal ☐ Transfer/Reason _____ ☐ Other_____

Personal Use records may incur a fee: (Florida Administrative Code, Department of Health, Costs of Reproducing Medical Records (64B8-10.003) rules) Copy Fee: $1.00 per page for first 25 pages, $.25 any pages over 25

I Hereby Authorize Treasure Coast Community Health (*Check One):*

☐ To Send To: ☐ To Receive From:

_____

Name of Provider, Facility, or Person

_____

Street Address, Suite #, Apt #

_____ _____ _____

City, State, Zip Code Phone Number Fax Number

Authorization to Release Protected Information:

Unless otherwise specified, only the following information will be released: Abstract includes most recent, (up to 2 years): Medical History, Medications, Progress Notes, Lab Reports, and Diagnostic Testing. **Other - (Please write below)**

Specific Documents Required: _____

***Required** – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's records.

Check One			*Initial Each Line Below*
I ☐	**DO** ☐	**DO NOT** want information about ***Mental Health** released	_____
I ☐	**DO** ☐	**DO NOT** want information about ***HIV Tests & Related Information** released	_____
I ☐	**DO** ☐	**DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

TCCH STAFF ONLY: ID VERIFIED_____STAFF MEMBER INITIALS

1. This authorization will expire in one year from the date signed. I hereby release Treasure Coast Community Health, its employees, vendors and/or independent contractors from any and all liability that may arise from the release of this information as I have directed.
2. I understand that Treasure Coast Community Health does not release medical records received from other physicians, facilities hospitals or emergency rooms. You must request these parties to send your medical records.
3. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Treasure Coast Community Health.

Patient's Signature: _____ **Date:**_____

Required for all patients 18 years & older

Signature of Parent or Legal Guardian: _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal rep documentation must be supplied)

12196 County Road 512
Fellsmere, FL 32948
Medical Fax 772-252-3263
Dental Fax 772-571-0189

44 N. Pine Street
Fellsmere, FL 32948
Fax 772-252-3263

13505 US Highway 1
Sebastian, FL 32958
Fax 866-880-8208

1553 US Highway 1
Vero Beach, FL 32960
Fax 772-675-9986

1545 9TH SW (Oslo Rd)
Vero Beach, FL 32962
Medical Fax 772-408-9624
Dental Fax 772-257-3150