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_____

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

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.

Specific Documents Required (such as Shot Record, Pap Test):_____

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.

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

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 representative documentation must be supplied)

TCCH STAFF ONLY: ID VERIFIED_____STAFF MEMBER

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