Mending Hearts Primary Care, LLC

7901 4th ST N #8298,
St. Petersburg Fl 33702
Phone: (813)-278-1241 Fax (833)-450-5156

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ **Birth Date:** _____ **Age:** _____

Social Security Number: _____ **Sex: M / F**

To Facility/Entity: _____

Phone: _____ **Fax:** _____

INFORMATION REQUESTED:

- ○ ENTIRE MEDICAL RECORD ○ PSYCHIATRIC RECORDS

****If only a portion of the medical record or psychiatric record is required please specify****

- ○ Discharge Summary
- ○ Emergency Room
- ○ Laboratory Results
- ○ History & Physical
- ○ X-ray Reports
- ○ Immunization Records
- ○ Operative Reports
- ○ Progress Notes
- ○ HIV Test/Status
- ○ Nurses Notes
- ○ Radiology Film/Imaging CD-ROM
- ○ Other _____

Date(s) of Service Requested:

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING VIA FAX: (833)-450-5156

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I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that id the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described about may be re-disclosed and no longer protected by these regulations I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Name of Patient (Print only) **Signature of Patient, DPOA, Guardian/Authorized Agent**

Relationship to Patient **Date**