

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Legal Insurance Personal Use Continued Medical Care Other (specify) TO - This information may be used and disclosed to and used by the following individual or organization: Patient Physician CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council Phone Fax	Patient Name:	Phone:	DO	3:	
Citrus County Rural Health Clinic (Crystal River) Facility/Physician: Phone: Fax: Zip: formation to be used/disclosed is specifically described below: Office Notes: Date(s) of Service: Date(s) of Service: Dignostics: Type of Report(s): Date(s) of Service: Other (Please specify): Date(s) of Service: Dote(s) of Service:	Address:	City:	State:	Zip:	
"acility/Physicia::	FROM - Patient authorizes the follo	wing facility/provider to disclose i	nformation specific	ally described below:	
Address:	Citrus County Rural Health Clini	ic (Crystal River)			
nformation to be used/disclosed is specifically described below: Office Notes: Date(s) of Service: Diagnostics: Type of Report(s): Date(s) of Service: Date(s) of Service: Other (Please specify): Date(s) of Service: Patient Patient CITRUS COUNTY RURAL HEALTH Patient' Phone Patient' Coperify date	Facility/Physician:	Phone:	Fax	<pre>** ** ** ** ** ** ** ** ** ** ** ** **</pre>	
Office Notes: Date(s) of Service: Diagnostics: Type of Report(s): Labs: Date(s) of Service: Other (Please specify): Date(s) of Service: Purpose of Disclosure: Legal Insurance Personal Use Continued Medical Care Other (specify) TO To his information may be used and disclosed to and used by the following individual or organization: Patient Physician CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council Phone Patient's Legal Council Phone CVNCounty and Induding this Authorization for Release of Medical Records ("Authorization") should only include medical records originated this Authorization for Release of Medical Records ("Authorization") should only include medical records originated this Authorization for Release of Medical Records ("Authorization") should only include medical records originated this Authorization for Release of Medical Records ("Authorization") should only include medical records originated this Authorization for Betaret refuest bailing to understands this Authorization for the Practice. Patient former understands this Authorization for the patient's 22N. Citary Rev. F. 3442A. Worker and and including this Authorization for Release of Medical Records ("Authorization") should only include medical records originated thorization and the patient of the statent the Practice. Patient former understands this Authorization for the patient's 22N. Citary Rev. F. 3442A. <	Address:	City:	State:	Zip:	
Diagnostics: Type of Report(s):	Information to be used/disclosed is spe	ecifically described below:			
Labs: Date(s) of Service:	Office Notes: Date(s) of Service: _				
Other (Please specify): Purpose of Disclosure: Legal Insurance Personal Use Continued Medical Care Other (specify) TO - This information may be used and disclosed to and used by the following individual or organization: Patient Physician CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council Phone Fax Curtorization shall expire one (1) year from the date of signature unless otherwise noted here: (Specify date) WORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should on the Practice. Patient was specifically requested. Platent further understand the authorization shall expire one (1) year from the date of signature unless otherwise noted here: (Specify date) WORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should on the further understand the subtorization and poinclude medical records originated through on the practice. Patient was specifically requested. Platent further understand the subtorization and poinclude medical records originated through on the practice. Patient was specifically requested. Platent further understand the Authorization and poinclude medical records originated through on the practice. Patient further understand the Authorization and poinclude medical records originated through on the practice. Patient on the practice has a condition for obtaining insurance coverage. Patient understands the Authorization for the requested shall not be extent the Mathorization provides. Authorization for the requested shall not continue transment port originated the practice has a condition for obtaining insurance coverage. Patient understands the Authorization for the requested shall not conting transment coverage.	Diagnostics: Type of Report(s):	D	Date(s) of Service:		
Purpose of Disclosure: <u>Legal hsurance Personal Use Continued Medical Care</u> <u>Other (specify)</u>	Labs: Date(s) of Service:				
Legal Insurance Personal Use Continued Medical Care Other (specify) To - This information may be used and disclosed to and used by the following individual or organization: Patient Physician CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council Phone Fax Copering of the state of the state of signature unless otherwise noted here: Cypering of the state of the state of signature unless otherwise noted here: Copering of the state of the state of signature unless otherwise noted here: WPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical vectors organizated throwing signature unless otherwise noted here: (Specify date) WPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical vectors organizated throwing signature transported by specifically requested. Patient (for the ruderstand shourd and on the state of signature on this Authorization or the the state of signature on this Authorization or the the state of signature transported by able of the state of signature on this Authorization") should only include medical vectors organizated throwing independent of the state of signature on the state of signature on the state of the	Other (Please specify):	D	Date(s) of Service:		
TO - This information may be used and disclosed to and used by the following individual or organization: Patient Physician CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council Phone Fax	Purpose of Disclosure:				
Patient Physician CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council Address: Phone	Legal Insurance Persona	al Use Continued Medical Care	Other (specify)		
CITRUS COUNTY RURAL HEALTH Address: Patient's Legal Council	TO - This information may be used	and disclosed to and used by the	following individua	l or organization:	
Patient's Legal Council Phone Fax Authorization shall expire one (1) year from the date of signature unless otherwise noted here: (Specify date) MPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical ecords dated prior to and including this Authorization. Patient understands this Authorization shall only include medical records originated through Citrus County Rural Health (the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands that butorization may be revoked at any time by notifying the CEO at Citrus County Rural Health: 927 N. Citrus Ave., Crystal River, FL 34428. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization or to the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient provides Authorization for the requested use or disclosure. Patient/Authorized Representative Signature Date	Patient	Physician			
Patient's Legal Council Phone Fax Authorization shall expire one (1) year from the date of signature unless otherwise noted here: (Specify date) MPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical ecords dated prior to and including this Authorization. Patient understands this Authorization shall only include medical records originated through Citrus County Rural Health (the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands that this authorization s voluntary and may refuse to sign. If patient refuses to sign, patient refusel will not affect patient's ability to obtain treatment from the Practice. Patient understands this Authorization may be revoked at any time by notifying the CEO at Citrus County Rural Health: 927 N. Citrus Ave., Crystal River, FL 34428. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization to rot the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient understands the Practice shall not condition treatment, payment and enrollment n a health plan or eligibility for benefits (if applicable) on whether Patient provides Authorization for the requested use or disclosure. Patient/Authorized Representative Signature Date	CITRUS COUNTY RURAL HEAI	LTH Address:			
Fax Authorization shall expire one (1) year from the date of signature unless otherwise noted here: (Specify date) MPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical records originated through condition of the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands this authorization shall only include medical records originated through solutary and may refuse to sign. If patient refuses to sign, patient refuses will not affect patient's ability to obtain treatment from the Practice. Patient understands this Authorization shall not be valid to the extent the Practice has taken action in reliance on this Authorization or to the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient understands the Practice shall not condition treatment, payment and enrollment n a health plan or eligibility for benefits (if applicable) on whether Patient provides Authorization for the requested use or disclosure. Patient/Authorized Representative Signature Date	Patient's Legal Council				
Authorization shall expire one (1) year from the date of signature unless otherwise noted here:		Phone			
(Specify date) MPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical ecords dated prior to and including this Authorization. Patient understands this Authorization shall only include medical records originated through Citrus County Rural Health (the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands that this authorization is voluntary and may refuse to sign. If patient refuses to sign, patient refusal will not affect patient's ability to obtain treatment from the Practice. Patient understands this Authorization may be revoked at any time by notifying the CEO at Citrus County Rural Health: 927 N. Citrus Ave., Crystal River, FL 34428. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization or to the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient understands the Practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether Patient provides Authorization for the requested use or disclosure.		Fax			
MPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical ecords dated prior to and including this Authorization. Patient understands this Authorization shall only include medical records originated through Citrus County Rural Health (the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands that this authorization is voluntary and may refuse to sign. If patient refuses to sign, patient refusal will not affect patient's ability to obtain treatment from the Practice. Patient understands this Authorization may be revoked at any time by notifying the CEO at Citrus County Rural Health. 927 N. Citrus Ave., Crystal River, FL 34428. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization or to the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient understands the Practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether Patient provides Authorization for the requested use or disclosure.	Authorization shall expire one (1) year f	from the date of signature unless othe	erwise noted here:		
ecords dated prior to and including this Authorization. Patient understands this Authorization shall only include medical records originated through Citrus County Rural Health (the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands that this authorization is voluntary and may refuse to sign. If patient refuses to sign, patient refusal will not affect patient's ability to obtain treatment from the Practice. Patient understands this Authorization may be revoked at any time by notifying the CEO at Citrus County Rural Health: 927 N. Citrus Ave., Crystal River, FL 34428. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization or to the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient understands the Practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether Patient provides Authorization for the requested use or disclosure.				(Specify date)	
	records dated prior to and including this Author Citrus County Rural Health (the practice) and/or is voluntary and may refuse to sign. If patient refu understands this Authorization may be revoked at However, revocation shall not be valid to the exter been executed as a condition for obtaining insura	rization. Patient understands this Authorizatio its affiliates unless otherwise specifically reque uses to sign, patient refusal will not affect patie c any time by notifying the CEO at Citrus County ent the Practice has taken action in reliance on ance coverage. Patient understands the Practic	n shall only include medica ested. Patient further under int's ability to obtain treatm y Rural Health: 927 N. Citrus this Authorization or to the se shall not condition treatm	al records originated through rstands that this authorization nent from the Practice. Patient s Ave., Crystal River, FL 34428. e extent this Authorization has nent, payment and enrollment	
Internal Use Only: Reviewed by	Patient/Authorized Representative Signatur	re	C	Date	
	Internal Use Only: Revie	wed by	on		