AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____Phone: _____ DOB: _____

Address:_____ City:_____State: _____Zip: _____

FROM - Patient authorizes the following facility/provider to disclose information specifically described below:

☐ Citrus County Rural Health Clinic (Crystal River)

Facility/Physician: _____ Phone:_____ Fax: _____

Address:_____ City:_____State: _____Zip: _____

Information to be used/disclosed is specifically described below:

☐ Office Notes: Date(s) of Service: _____

☐ Diagnostics: Type of Report(s):_____ Date(s) of Service:_____

☐ 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 - This information may be used and disclosed to and used by the following individual or organization:

☐ Patient

☐ CITRUS COUNTY RURAL HEALTH

☐ Patient's Legal Council

☐ Physician _____

Address: _____

_____

Phone _____

Fax _____

Authorization shall expire one (1) year from the date of signature unless otherwise noted here: _____

(Specify date)

IMPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical records 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.

_____

Patient/Authorized Representative Signature Date

Internal Use Only: Reviewed by _____ on _____

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