dedicated to your health

1223 Gateway Drive • Melbourne • Florida • 32901
321-725-4500 Ext. 7307 Fax# 321-724-8069

Authorization For Release of Protected Health Information

(PLEASE ALLOW 7 TO 14 BUSINESS DAYS TO PROCESS)

Requesting Physician: _____ MRN# _____

Patient 's Full Name: _____ DOB: ___/___/___
(Please print clearly)

Phone: (Hm) ( ) _____ (Wk) _____ (Cell) _____

Can leave voice message on: Home phone _____ Work phone _____ Cell Phone _____

Address: _____

City: _____ State: _____ Zip code: _____

Please check one: Mail copies_____, Mail CD_____, Fax to: ( ) _____

Myself or representitive _____ to pick up Copies_____ or CD_____

**Records pick up at 1223 Gateway Drive, Melbourne **(records will be held for only 14 days)*

I, the undersigned, authorize and request Melbourne Internal Medicine Associates copy or request the following information from my medical record(s) for care and/or treatment that I receive from the dates of service: _____ to _____

Specific records only _____ All MIMA records _____

Please *do not release* the following: _____

Release to: MIMA _____, Patient/self/person _____, Facility/office/person below _____

Obtain records from facility/office noted below _____

Person/Organization/ Physician _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Less than 25 pgs. to be faxed: ( ) _____

The Protected Health Information may be used or disclosed for the following purposes:
Healthcare _____ Insurance _____ Legal _____ Personal _____ Other _____

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Authorization For Release of Protected Health Information

- Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment and/or examination related to mental health related care, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.

- By signing this release, you understand that this authorization will remain in effect for 180 days or until revoked in writing (whichever transpires first). MIMA is authorized to use outside vendors for the purpose of copying and providing the information requested.

- I understand that the state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that MIMA cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

- I understand I have the right to inspect and obtain a copy of any information disclosed.

- I hereby release MIMA and its employees from any and all liability that may arise from the release of information as I have directed.

- I understand that if I have requested duplication of records within a one year time period (of the same or similar records), I may be charged a fee of up to $1.00 per page for every page copied. This fee may be waived for copies provided to a health care provider, insurance company or other specific organizations for treatment, billing or operations purposes.

Signature of Patient: _____ Date: _____

*A photo ID must be provided for proof of identity or release must be notarized. ID checked by _____

Empowered Representative: _____ Date: _____

*Must provide POA or supporting documentation for personal representative or healthcare surrogate

Relationship to patient: _____

Witness: _____ Date: _____

Staff use only

ID checked, YES / NO Request processed by: (initials) _____ Date: _____

Modified 05/10