ESCRIBA MEDICAL GROUP

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

I, _____, authorize the release of medical records/protected health information as specified in this authorization for the above-named patient.

FROM

ESCRIBA MEDICAL GROUP
Dr. ABELARDO ESCRIBA

11925 Southern Blvd, Ste 3

Royal Palm Beach, FL 33411

Phone: 561-408-3437

Fax: 1-866-531-7994

TO

Physician/Facility:

Address:

Phone:

Fax:

TO

ESCRIBA MEDICAL GROUP
Dr. ABELARDO ESCRIBA

11925 Southern Blvd, Ste 3

Royal Palm Beach, FL 33411

Phone: 561-408-3437

Fax: 1-866-531-7994

FROM

Physician/Facility:

Address:

Phone:

Fax:

INFORMATION TO BE DISCLOSED:

- ☐ Complete Medical Record
- ☐ Records of visit for specific date(s): Date(s):
- ☐ Test Results Only
- ☐ Consultation Notes Only
- ☐ Operative/Procedure Reports
- ☐ Other:

PURPOSE OF DISCLOSURE:

- ☐ Continuity of Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ Other:

ACKNOWLEDGEMENT OF UNDERSTANDING

• I understand my records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law.

• I understand once my information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA.

• I understand my records may contain information pertaining to treatment/diagnosis of mental health, drug and alcohol abuse, and communicable diseases including HIV/AIDS.

• I understand that signing this authorization is voluntary and will not affect my receipt of treatment.

• I understand I may revoke this authorization at any time, in writing, provided that the information has not yet been released.

• I understand this authorization will expire in 1 year or until I revoke it in writing.

Date:

Patient or Authorized Representative Signature:

Relationship to Patient: Self