6547 SW State Road 200
Ocala, FL 34476
Http://surgeryccfl.com/

Surgery Center of Central Florida
Authorization for Use of Disclosure of Protected Health Information
Health Information Management Department

PATIENT NAME: _____ SS: XXX-XX-_____

DATE OF BIRTH: _____ PHONE: _____

Send Information to:(Print name of person, organization or agency with full address of where records are being sent.)

Name: _____ Fax: _____

ATTENTION MEDICAL RECORDS Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose of Release (Continued Care, Personal, etc.): _____

PLEASE NOTE: AS A GENERAL RULE, WE ONLY COPY AND RELEASE RECORDS GENERATED BY THIS FACILITY.
THERE MAY BE A FEE CHARGED AS ALLOWABLE BY FLORIDA LAW.

TO THE PATIENT

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination. As required by state and federal law, Surgery Center of Central Florida may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorizations, but the Surgery Center of Central Florida cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition. I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Health Information Management, Surgery Center of Central Florida 6547 SW state road 200, Ocala, Fl. 34476. I further understand that any such revocation does not apply to the information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization. I hereby release The Surgery Center of Central Florida and all employees from any and all liability that may arise from the release of information as I have directed.

I hereby authorize Surgery Center of Central Florida to release information as described above.

Patients Signature_____ Date_____

Signature of Parent or Guardian_____ Date_____

Relationship to Patient_____