Date______________   **Time**_______________

Mark E. Petrites, M.D., F.A.C.S.

General Surgery – Advanced Laparoscopic Surgery Ph: (239) 495-3990 Fax:(239) 949-2888

Authorization for Disclosure of Medical Record Information

Patient's Name______________________D.O.B.________SS#_____________

I, the undersigned hereby authorize and request ________________________ to release to: ___________________________________the medical record of: ____(pt name) for the purpose of: [ ] Treatment of the patient [ ] Payment [ ] Health care operations [ ] Other

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure and except as otherwise provided by law, such information may not be disclosed without my specific consent. I understand the "minimum necessary" rules may apply. Additionally, I have the right to refuse disclosure and prevent any other person from disclosing such information. Such information includes information pertaining to (1) treatment for mental or emotional conditions, (II) alcohol/drug abuse or (III) HIV testing or test results.

Information to be released/disclosed (check all that apply):

____Entire Medical Record (including if any, mental health information, substance abuse Information, HIV testing information and results.

____Laboratory Results

____Dr Notes

____HIV Testing information and results

____Progress Notes

____Diagnostic Studies

____OP Notes

____Other

I do hereby agree to release, indemnify and hold harmless, Mark E. Petrites, M.D., P.A., its directors and employees from and against any claims or liability by it or any item, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent.

This consent and authorization shall expire upon written revocation from the patient or authorized representative.

________________________________   ______________________________

Signature of Pt. or Authorized Representative   (Print Name)

____

Relationship to patient

____

____

Address and phone number

If the person requesting the information is not the patient please complete the following:

Name: ____

Buisness____

Address: ____

Home phone: __________________Work: ______________ Cell: _____________

Relationship to the patient:
( ) Spouse ( ) Parent ( ) Child ( ) Grandparent ( ) Grandchild
( ) Aunt/Uncle ( ) Attorney representative ( ) Legal Guardian
( ) Other______________________________

I certify that the information on this request form is true and accurate to the best of my knowledge, and shall not use or disclose the information received from Mark E. Petrites, M.D., P.A. for any other purpose other than listed on this form. I further understand I am bound by the terms of this form and the accompanying authorization (if applicable) until such time that I return the information to Mark E. Petrites, M.D., P.A. or destroy all copies of the information in my possession.

____
Signature of person requesting PHI date

____
Printed name
==
FOR OFFICE USE ONLY

Verified identity using: [ ] Driver's License [ ] Work/Gov't ID
[ ] Company/Agency letter [ ] Other: _____________

Verified authority to request information using:

[ ] Patient's current authorization [ ] Written authority on agency letterhead
[ ] Judicial subpoena/court document [ ] Other: ___________________________

Number of patient records included in this request: _______________

[ ] Request approved by __________________________ on ________________________.

[ ] Information sent to recipient via _____________________ on ___________________.

Released by____date________________.