Our Family Doctors

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

I hereby authorize *Our Family Doctors* to: ◯ **disclose / release TO** ◯ **obtain FROM**

Doctor or Facility Name | Telephone | Fax

Address | City | State | ZIP

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain personally identifiable information and protected health information (PHI) as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a written notice, to the Office Manager. If I choose to limit the information released, I understand that *Our Family Doctors* may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to redisclosure by the recipient and no longer be protected by *Our Family Doctors*. *Our Family Doctors* and staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein. **Unless revoked, this authorization will expire one year from the date of signature or on the following date_____.**

◯ **ALL** medical records without exception, including: clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease, consultations, secondary records, etc.

◯ **PARTIAL** medical records which may include HIV testing and treatment, mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease and other sensitive information.
Please specify parts and dates to be released if not "all":

◯ progress / visit notes_____	◯ Immunizations_____	◯ other_____
◯ x-ray reports_____	◯ allergy_____	◯ other_____
◯ lab reports_____	◯ physical exam_____	◯ other_____
◯ immunizations_____	◯ consultations_____	◯ other_____

This request is for the purpose of treatment / continuation of care.

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS INDICATED ABOVE.

Signature of patient or legal guardian | Printed Name | Date

Address | City | State | ZIP

Telephone | Date of Birth | Social Security Number | Other Name under which records may be found

IF RECORDS ARE BEING REQUESTED FROM ANOTHER PRACTITIONER OR FACILITY, THEY SHOULD BE FORWARDED TO:

◯	◯	◯	◯
Matthew Duke, DO 2 North Belcher Road Clearwater, FL 33765 Phone: 727-449-2224 Fax: 1-855-265-5780	Matthew Duke, DO 2780 East Bay Drive Largo, FL 33771 Phone: 727-535-3489 Fax: 1-866-878-4914	Mary J. King, DO 10225 Ulmerton Rd, Suite 1A Largo, FL 33771 Phone: 727-585-7408 Fax: 1-866-980-2443	Administration, OFD James R. Kinney, Sr., DO 10225 Ulmerton Rd, Suite 1B Largo, FL 33771 Ph: 727-581-4849 Fax: 727-584-7429