Cleveland Clinic
Martin Health

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please Print Clearly ***M#***_____

Patient's Name: _____ **Date of Birth:** _____
First **Middle (if any)** **Last**

Home Address: _____ **Telephone:**_____

_____

The undersigned hereby requests and authorizes the release of records from the following Cleveland Clinic Martin Health location(s):_____

LIST PHYSICIAN/OFFICE & ADDRESS OR HOSPITAL LOCATION (s) AS APPLICABLE

To: _____
[RECIPIENT OF YOUR RECORDS] **Full Name** **Mailing address** **[*MUST BE COMPLETED*]**

_____
City **State** **Zip Code**

_____
Telephone Number **Fax Number** **E-Mail Address**

Please check the box next to each type of records you would like to be disclosed (Include visit dates on line provided for each)

- ☐ Most recent History & Physical or specific date(s): _____
- ☐ Most recent Discharge Summary or specific date(s): _____
- ☐ Most Recent Lab Result or specific date(s): _____
- ☐ Pathology Report, specify date(s): _____ ☐ Slides: _____
- ☐ Radiology & other diagnostic reports/testing results, specify date(s): _____ ☐ Films: _____
- ☐ Entire Record, specify date(s): _____
- ☐ Abstract*, specify date(s): _____
  [*a **summary of your visit** that contains pertinent information about your treatment such as discharge summary, history and physical, consultations, operative reports, lab results, diagnostic results and reports.]
- ☐ Physician Office Notes, specify date(s): _____
- ☐ Billing, specify date(s): _____
- ☐ Other, specify visit type and date(s): _____

Certain confidential information may be in your records. Please check below to specifically authorize disclosure of:

- ☐ HIV/AIDS Test Results/Record notations
- ☐ STD Records (Sexually Transmitted Diseases)
- ☐ Mental Health Treatment Records (excluding **Psychotherapy Notes** - **separate authorization form required for release**)
- ☐ Drug & Alcohol Treatment Records
- ☐ Genetic Testing

PURPOSE(s) of request [*MUST BE COMPLETED*]:_____

Records will be released on paper. For records on CD, check here ☐

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. I understand that I may revoke this authorization at any time, in writing, to the address listed below, **ATTN: Health Information Management Department**, provided that the information has not yet been released.

This authorization expires in six (6) months unless another date is written here: _____

Patient or Authorized Signature: _____ **Date:** _____

Relationship to Patient: _____ **Witness:** _____ **Date:** _____
Explain and/or attach Legal Documentation