VOLUSIA MEDICAL CENTER

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Priscilla Luong, MD John S. Yee, MD Jonathon Treece MD Adam Hall DO Harvey Schefsky MD
Anthony Lagana, ARNP Sharon Yelle ARNP Jennifer Wood ARNP

Authorization to Release Medical Records

Patient Last Name, First Name, Middle Initial	❑M ❑F	Age	Date of Birth	Social Security Number
Street Address, City, State, Zip				Telephone Number

I authorize the following organization to release information as stated below from the patient health information record:

Information to be released *FROM*:	**Information to be released *TO*:**
_____ Organization _____ Street Address City, State, Zip _____ Phone Fax	_____ Organization _____ Street Address City, State, Zip _____

Information to be Released:

Dates of Service for Records Requested: Beginning_____Through_____
❑Entire Chart ❑Labs ❑Radiology ❑Other Testing ❑Clinic Notes ❑ Vaccination Record
❑ Other (please specify)_____

Purpose of Release:

❑Continuing Care ❑Transfer to another provider ❑Copies for own use ❑Legal Purposes
❑Other (please specify)_____

Authorization for General Release of Information:

This Authorization:
❑ is voluntary and is not required for obtaining treatment of payment, unless the sole purpose of this Authorization is to determine payment of a claim for benefits
❑ will expire in 12 months from the date signed below unless another date or event is entered here_____
(Note: If the disclosure is to an employer or financial institution, this authorization will expire in 90 days from the date you signed)
❑ may be revoked at any time by writing to Volusia Medical Center, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected

The following sensitive records require specific patient authorization. Please Check the applicable box below to request the following records:
❑ Sexually Transmitted Diseases ❑ AIDS/HIV ❑ Alcohol/Drug Abuse Treatment ❑ Mental Health Treatment

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.
Release: I release Volusia Medical Center, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

Signature of Patient/Legal Representative:

Date: Signature: Relationship to Patient:

Signature of Minor Patient Required for the following Record:

Required in releasing information related to reproductive care, Sexually Transmitted Diseases and substance abuse/mental health treatment.
Date: Signature: