UROLOGY CENTER of WINTER PARK

TopLine MD Alliance

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Authorization to Obtain Records

Patient's Name: _____ DOB:_____

SSN:_____ Phone Number: _____

I hereby authorize the release of medical records to Urology Center of Winter Park.

From: _____

Address:_____

Phone Number:_____ Fax Number: _____

Reason for Disclosure: _____ Medical Care _____Insurance _____ Patient request

_____ Other, explain _____

Items to be Disclosed: _____ Complete Medical Records _____ Labs _____ Recent Office Visit

_____ Radiology _____ Procedure/Operative/Pathology

I understand that my medical record may also include information on the diagnosis/treatment related to psychiatric conditions, drug/alcohol abuse, acquired immune deficiency, HIV testing or the fact a HIV test was performed and/or sexually transmitted diseases.

Time Limit of Request: I understand that this authorization is valid thru _____ and if left blank then for one year from date of request.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will NOT apply to insurance companies when the law provides my insurance with the right to contest a claim under my policy. I understand that any disclosure of information carries with it the potential for any unauthorized disclosure and information may not be protected by federal confidentiality rules. I accept the risks of faxing Protected Health Information. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except by law. I understand that in compliance with Florida Law, I may be required to pay a fee for supplying records.

Patient/Guardian Signature: _____ Date: _____