

David J. Krull, M.D.
Raymond L. Raitz, M.D.
James A. Briles, M.D.
Kevin P. Lipscomb, M.D.
Anthony R. Hemmer, M.D.
Kathleen A. Greenfield, PA-C
Aimee L. Goldman, PA-C



NORTH RIVER

Family Health Center, P.A.

606 4th Avenue West
Palmetto, Florida 34221-5295
(941) 722-7785 Telephone
(941) 729-5267 Fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT: _____

BIRTHDATE: ____/____/____
MO DAY YEAR

ADDRESS: _____

SSN: _____

PHONE: _____

Contact/Pick-up Designee: _____

Released FROM: _____

Released TO: _____

MEDICAL INFORMATION TO BE DISCLOSED:

___ All Records ___ EKG

___ Lab ___ X-ray ___ Immunizations

___ History & Physical

___ Consultations ___ Registration Into ___ Other: _____

REASON FOR REQUEST: _____

___ Mail Copies

___ Patient/Designee to Pick-up

Copies to: (Individual or Organization Name) _____

Street Address: _____ City/State/Zip: _____

As set forth in the practice's Notice of Privacy Practices, I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so by notifying this office in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I have the right to refuse to sign this authorization or to inspect my protected health information to be used or disclosed as permitted under federal and state laws. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer at (941) 722-7785.

Patient /Legal Representative Signature

Date

Print Name