LABRADOR PRIMARY CARE CENTER PATIENT NAME_____ DOB _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO LABRADOR PRIMARY CARE CENTER

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to Labrador Primary Care Center and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.
I further authorize you to provide to and discuss with Labrador Primary Care staff and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Authorized to release medical records:

Dr. _____

Address: _____

Phone (_____) _____-_____ **Fax (_____) _____-_____**

Release medical records to: LABRADOR PRIMARY CARE CENTER

❑ **6775 Crosswinds Dr. N, St. Petersburg, FL 33710** **Ph: 727-381-8006** **Fax: 727-381-9629**

❑ **2191 9th Avenue N, #220, St. Petersburg, FL 33713** **Ph (727) 327-9667** **Fax: 727-321-1655**

Which Records? ALL medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports. Include the following **circled** items:

Progress notes	**Case Manager notes**	**Mammogram**	**Echo / Stress test**
Emergency Dept notes	**Discharge Summary**	**Colonoscopy / FOBT**	**EKG**
Operative Reports	**Labs**	**DEXA**	**ALL MEDICAL RECORDS**
Consultation Reports	**Radiology reports**	**Eye exam**	

Purpose of Disclosure: Continuity of care

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release of information may no longer be protected by Federal privacy regulations. I understand that I am not required to sign this Authorization to ensure treatment and I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. 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 rule. This authorization shall remain valid for 12 months from the date signed below.
Any re-disclosure of this information by recipient is not protected under this authorization.

Signature _____ _____/_____/_____
Patient or Patient Representative Date

Relationship of Patient Representative (if applicable) _____

1st request _____ 2nd request _____ 3rd request _____