Authorization to Disclose Protected Health Information

The undersigned authorizes **Medical Specialists of the Palm Beaches, Inc.**
5700 Lake Worth Road, Suite 204 Lake Worth, FL 33463
Fax: (561)649-7028
to release my health information as noted below:
******All sections must be completed in order for request to be processed******

Patient Information

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____ **Other Names?** _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To (THIS SECTION MUST BE COMPLETED)

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address and name of your designated recipient if electronic delivery is chosen.

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Information to be Released (THIS SECTION MUST BE COMPLETED)

If you fail to specify, 1 year of records will be provided.

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy

Specify Date(s) of Service: _____

*Body Part:*_____

☐ **Other** (please specify):

_____

Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at 866-967-0133

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.
At no time will the cost-based fees exceed FL law (395.3025 (1))

I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

DELIVERY METHOD	[ ] Send by Email*	[ ] Mail Records on CD	[ ] Mail Records on Paper

A valid email must be provided above. If you do not select a delivery method, Sharecare will determine the delivery method based on the information provided on this form.* **No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial*)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**
_____. *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*