**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**
**FROM OTHER HEALTHCARE FACILITIES**

Patient Name:_____

Telephone #:_____ Date of Birth: _____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Name of Healthcare Facility from which Records are Requested:

_____ Ph: _____ Fax: _____
(Please Print)
Address:_____ City:_____ State:_____ Zip:_____

Dates of Treatment Requested: _____ Reason for Disclosure: _____

MAIL INFORMATION TO: **MY FAMILY PHYSICIANS, INC.**
**5801 NW 151st Street, Suite No. 307 Miami Lakes, FL 33014**
Fax To: **786.360.6586** Or Email To: **myfamilyphysicians@yahoo.com**

I authorize **MY FAMILY PHYSICIANS., (MFP) to obtain** the health information indicated below **AND** for the purpose of alternative means of confidential communication the use of their Email Address.

**MFP** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **MFP** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **MFP** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Check a Box ☑

| | | | |
|---|---|---|---|
| | Complete Record | | Radiology Reports |
| | Lab Reports | | Pathology Reports |
| | Operational Reports | | Other (Specify) |

**SPECIFIC AUTHORIZATIONS**

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:
☐ Drug/ Alcohol Abuse or Treatment ☐ HIV/ AIDS or Sexually Transmitted Disease (STD) Test Results or diagnoses
☐ Genetic Testing Information ☐ Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon**. This authorization and consent will expire one year from the date of authorization written below.**
Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____/_____/_____
Signature of Patient or Legal Representative

Printed Name: _____ Relationship if not Patient: _____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.