# Medical Records Release

## Medical Records Custodian - Stuart Office

1050 SE Monterey Rd. Suite 101 Stuart, FL 34994 p. 772.419.0560 f. 772.403.2379

TREASURE COAST Primary Care

I,_____direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

_____ Name/Organization

_____ Relationship or Purpose

_____ Contact Phone

_____ Fax Number

_____ Name/Organization

_____ Relationship or Purpose

_____ Contact Phone

_____ Fax Number

**Health Information to be disclosed** upon the request of the person named above.

☐ **Disclose my complete health record**
(Including but not limited to diagnoses, lab tests, prognosis, treatment and billing for ALL conditions)

☐ **Disclose my health record as above <u>BUT DO NOT INCLUDE</u>**

- ☐ Mental health records
- ☐ Alcohol/Drug treatment
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Other (please specify) _____

**Form of Disclosure** (check all that apply - electronic media includes CD, DVD, hard drives and USB media)

- ☐ An electronic record or access through an online-portal
- ☐ Hard copy

This authorization shall be effective until:

- ☐ All past, present, and future periods, **OR**
- ☐ Specific Dates: from_____to _____

*You may revoke this authorization at any time by notifying us in writing*

_____ Name of the Individual Giving this Authorization (print)

_____ Date of birth

_____ Signature of the Individual Giving this Authorization

_____ Date