

CENTURY CLINICAL FAMILY MEDICINE LLC

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS, PER ORS 192.525

PHONE: 386-274-4750 FAX: 386-274-2499

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

**From: Century Clinical Family Medicine LLC
1410 LPGA Blvd, Ste 136,
Daytona Beach, FL 32117**

To: _____
(Name of hospital/health care provider)

(Address of recipient)

To disclose a copy of the medical information for:

(Name of patient) (Date of Birth) Social Security Number

Information to be Used or Disclosed

By initialing the spaces below, I specifically authorize the disclosure of the following medical records, if such records exist:

- | | | |
|--|--|--|
| <input type="checkbox"/> Hospital records (including nursing records and progress notes) | <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Clinician office chart notes |
| <input type="checkbox"/> Most recent five-year history | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Physical therapy records |
| <input type="checkbox"/> Transcribed hospital records | <input type="checkbox"/> Billing statements | <input type="checkbox"/> Emergency and urgent care reports |
| | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Diagnostic imaging reports | |

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

PROTECTED OR SENSITIVE INFORMATION: I UNDERSTAND THAT CERTAIN INFORMATION CAN NOT BE RELEASED WITHOUT SPECIFIC AUTHORIZATION AS REQUIRED BY FEDERAL/STATE.
BY INITIALING, I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED OR SENSITIVE INFORMATION:
 HIV/AIDS related records Mental health information
 Genetic testing information Drug/alcohol diagnosis, treatment or referral information

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Family Practice Group. You should contact the Office Manager/Compliance Officer to terminate this authorization. The only exception is when action has already been taken in reliance on the authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

(Date) (Signature of patient or person authorized by law)

Relationship of Patient Representative to Patient (if signed by other than the Patient)