CENTURY CLINICAL FAMILY MEDICINE LLC

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS, PER ORS 192.525

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

I hereby give authorization to: ______________________________
(Doctor's Office, Clinic, Hospital, Specialist, Other)

____
(Street Address)

____
(City State, Zip)

Phone:_________________________

To release and disclose to:
Century Clinical Family Medicine LLC
1410 LPGA Blvd, Ste 136
Daytona Beach, FL 32117
Phone: (386)274-4750
Fax: (386) 274-2499
*Secure Upload Records at http://centuryclinical.leapfile.net
Recipient Email: records@centuryclinical.com

For:

__________________________	____________	______________________
Patient Name	**D.O.B.**	**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:

____ Home Health records
____Hospital records & progress notes
____ Pathology Reports
____Most Recent Five-Year History
____ Laboratory reports
____ Diagnostic Imaging Reports
____Clinician Office Chart Notes
____Physical Therapy Records
____Emergency & Urgent Care Reports

____ **PLEASE SEND THE ENTIRE MEDICAL RECORD (all information) to Century Clinical Family Medicine LLC as listed above.**

PROTECTED & SPECIAL PRIVILEDGED HEALTH INFORMATION

I acknowledge and understand that certain information cannot be released without specific authorization as required by Federal and State Law. By initialing below, I authorize the additional or specific release of the following protected or sensitive information:

____ HIV/AIDS related records (including lab results)
____ Domestic or Sexual Violence (including therapy)
____ Behavioral/Mental Health information
____ Genetic/DNA testing
____ Drug/Alcohol Abuse, treatment

Expiration Date:

This authorization is effective through ________________________ unless revoked or terminated by the patient or other authorized signer or representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Century Clinical Family Medicine. You should contact the Office Manager or 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 Century Clinical Family Medicine 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 patient)