evolution
primary care

11264 Boyette Road Riverview, Florida 33569
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Name: ____ Date of Birth: __________________________

Facility/Doctor requesting records from: ____

Facility/Doctor Telephone #: ___________________________

I hereby authorize the disclosure of the following health record information:

( ) Complete Health Record ( ) History And Physical ( ) Discharge Summary
( ) Progress Notes ( ) Laboratory Test Reports ( ) X-Ray Reports
( ) Consultation Reports (specify):
( ) Other (specify):
( ) Purpose of Request:____

I understand this authorization may be revoked in writing at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. The above information will not be given, sold, transferred, or in any way related to any other person not specified in the consent form without first obtaining my additional written consent. I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentially rules. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

I understand that records submitted to or from other health care providers (3rd parties) may be included in my health records and will be sent unless noted below.

❑ Do not send any records from any other health care providers.

SENSITIVE INFORMATION:

❑ These records may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), treatment for a psychiatric condition or evidence of alcohol or drug abuse. I understand that this sensitive information is protected by law under certain conditions. By signing this statement, I authorize release of this information to the requesting party.

❑ Do not send any sensitive information protected by law except _____________________________________.

Send information to:

Evolution Primary Care
Dr Matthew Dowdy
11264 Boyette Road Riverview, FL 33569
T#: 813-672-2014
F#: 866-386-1733

____ ________________
Signature of Patient / Legal Guardian / Authorized Representative Date

____
Relationship to patient

____ ________________
Witness Date