Just Ladies Healthcare of the Treasure Coast, LLC

1304 N Lawnwood Circle, Fort Pierce, FL 34950
Phone (772) 489-6636 Fax (772) 489-5749

Medical Records Release

Patient's Name	Date of Birth	Acct#
Patient's Address		**Patient's SS#**

Purpose of Release:

___Attorney ___Continued Care ___Disability ___School ___Personal Copy

___Other(specify):_____.

Date(s) of Treatment _____.

I hereby authorize Just Ladies Healthcare:

___Obtain ___Release of Patient's PHI:	___Obtain ___Release of Patient's PHI:
Name	**Name**
Address	**Address**
Phone	**Phone**
Fax	**Fax**

Information to Obtain/Release:

___Face Sheet/Insurance Info ___Consultations ___Lab Reports ___Office /Progress Notes

___History & Physical ___Discharge Summary ___Pathology Report ___Operative Report

___X-Ray & Ultrasound ___Psychiatric Consult ___Drug and/or Alcohol Abuse

___Other(specify):_____.

I UNDERSTAND AND AGREE THAT THE INFORMATION I AM AUTHORIZING TO BE RELEASED MAY INCLUDE:

(1) AIDS/HIV TEST RESULTS, DIAGNOSIS, TREATMENT AND RELATED INFORMATION; FLORIDA STATUE394.459(9)

(2) MENTAL HEALTH INFORMATION, (FLORIDA STATUES 397.053 & 396.112)

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION, AND THAT THE INSTITUTIONS NAMED ABOVE CANNOT DENY OR REFUSE TO PROVIDE TREATMENT.

I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR SIX (6) MONTHS OR UNTIL I REVOKE IT IN WRITING OR BY VERBAL NOTICE TO ANY AUTHORIZED EMPLOYEE OF JUST LADIES HEALTHCARE. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO ANY ACTIONS ALREADY TAKEN AS A RESULT OF THIS AUTHORIZATION.

I UNDERSTAND THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY NO LONGER BE PROTECTED BY THE FEDERAL MEDICAL PRIVACY LAW AND COULD BE DISCLOSED BY THE PERSON OR AGENCY THAT RECEIVES IT.

I UNDERSTAND THAT I MAY BE CHARGED A FEE OF UP TO $1.00 PER PAGE FOR THE FIRST 25 PAGES OF WRITTEN MATERIAL AND $.25 FOR EACH ADDITIONAL PAGE.

I have read and understand the information in this authorization

Patient Signature _____ Date: _____