AUTHORIZATION FOR RETRIEVAL OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (RELEASE OF INFORMATION)

Patient Name: _____
Last First MI

Date of Birth_____/_____/_____ **SS#**_____-_____-_____

_____
Address City State Zip

Day Phone: (_____**)**_____**Evening Phone: (**_____**)**_____

I authorize: _____
(Name)

_____
(Address) (City) (State) (Zip)

(_____)_____ (_____)_____ TO:
(Phone Number) (Fax Number)

_____ Receive information from: _____ Send information to: (please check ONE or BOTH)

CHARLES E. AHNER, M.D.
Ahner Medical Center
25 NE Dixie Hwy.
Stuart, FL 34994
Phone: (772) 692-9200
Fax: (772) 692-9888

Information to be Released	Purpose of Disclosure
o **Entire Medical Record** o **Office Notes For**_____ o **Medication List, Problem List** o **Most Recent Diagnostic Test** o **X-Ray Reports for**_____ o **Lab Reports For**_____ o **Drug/Alcohol, AIDS/HIV STD, Mental Health info** o **Other**_____	o **Treatment** o **Payment** o **Health Care Options** o **Continuing Care** o **Patient Request**

- **Drug/alcohol, AIDS/HIV STD, mental health information records release:** I understand that my medical record may contain sensitive information and may be subject to redisclosure to the extent permitted by the disclosure**. INITIAL**_____
- **Right to Revoke Authorization:** I understand that I may revoke this authorization at any time **in writing** to Dr. Ahner's office. Unless specified in writing, this authorization will expire one year from today's date. I further understand that my health care and payment for my health care will not be affected if I do not sign this form. **INITIAL**_____
- **Redisclosure:** I may no longer be protected by federal privacy laws**. INITIALS**_____
- **Right To Inspect:** I understand that I have a right to inspect or copy the protected health information or to be used or disclosed. However, I understand that a charge may be incurred to copy these records**.** **INITIALS**_____

_____ _____ _____
Signature of Patient **Relationship to patient** **Date**