Medical Center Clinic
Authorization to Release Medical Records

Fax completed form to 850.474.8022 or bring to Release of Information (1st Floor, Bldg 1).

PATIENT INFORMATION	Name:	Date of Birth:	
	Address:	Daytime Phone:	
	City:	State:	Zip:
	Email:	Date Submitted:	
MEDICAL CENTER PROVIDER List the MCC providers for which you want records sent.	☐ ALL	☐ NON-MCC PROVIDER (specify provider below)	
	1)	Specialty	
	2)	Specialty	
	3)	Specialty	
RECEIVING PARTY ***Where*** do you want the information sent? ***Who*** do you want to have the information?	☐ Self	**Complete All Sections Below For Proper Delivery**	
	Name:	Phone No.:	
	Address:	Fax No.:	
	City:	State:	Zip:
	Attention to:		

INFORMATION TO BE RELEASED
What do you want sent or released? Check the appropriate box.

Type of Record	Start Date	End Date	Type of Record	Start Date	End Date
☐ ALL MCC records			☐ Operative Report		
☐ Billing			☐ Pathology		
☐ IV Therapy			☐ Physical Therapy		
☐ Lab			☐ Office Note		
☐ Mental Health			☐ Radiology		
☐ Neurodiagnostic			☐ Sleep Study		

RELEASE and DELIVERY INSTRUCTIONS
How and ***When*** do you want the information delivered?

Date record is needed:_____ **(NOTE: Allow 7-10 business days for processing)**

FORM OF MEDIA FOR DELIVERY OF RECORDS (If left blank, a paper copy will be provided)

☐ Paper (USPS Mail or Pick-up) ☐ USB Drive, CD/DVD (pre-payment required)

☐ Fax (to Fax No. of Receiving Party Above)

☐ Encrypted email to this email address: _____

***NOTE:** In the event MCC is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when Receiving PHI in electronic format or email.

PURPOSE OF RELEASE
Why is it needed?

☐ Treatment (Patient Care) ☐ Litigation/legal** ☐ Personal**

**Pursuant to F.S. 452 and Federal Rule 45 C.F.R. §164.524, a fee of $1.00 per page for the first 25 pages and .25 per page thereafter plus applicable shipping may be charged.

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Medical Center Clinic's (MCC) Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- MCC will not restrict my treatment if I choose not to sign this authorization.
- A photocopy, fax, or scanned image of this authorization will be treated in the same way as the original.
- MCC records may include records that it received from other organizations. If these records have been used by MCC and filed in the record MCC maintains about you, these records may be released with your MCC records.
- MCC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release MCC from any and all liability resulting from a re-disclosure by the recipient.

Signing (or typing) your name below indicates you have read and understand this form, and authorize, or are authorized, to release the information as requested above.

_____ Patient/Legal Representative Signature

_____ Authority to act on behalf of patient (attach document)

SUBMIT

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Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for)

Provider: Identify which MCC provider you are seeking information from (or to be sent to). **Please be specific** in your request. If you do not identify a specific provider, records may be provided for ***ALL*** MCC providers from whom you have received care. Visit www.medicalcenterclinic.com/providers for a listing of all MCC's providers.

Receiving Party: Identify the full name/business, address, phone and contact information for the name of the individual who is *to receive* the information. ***Please allow 7-10 days for all requests to be processed and sent to the recipient.***

Information to Be Released: This section gives us the instructions for what information you want released. If you select mark a specific type of record, such as physical therapy, we will provide only those records. If you select "ALL records", your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor.

Release and Delivery Instructions: This tells us how you would like your information delivered. We can print the records, send the records by fax, or provide your records in electronic format. Electronic records can be stored on a USB drive or e-mailed to the recipient. Radiology images will be provided on CD.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event. You may indicate the consent is valid "5 years", "10 years", but there needs to be an ending date. The authorization is revoked at your written direction to MCC's Release of Information Department.

This form can be faxed to 850.474.8022 or delivered to the ROI department located on the first floor of building 1, across from the Diagnostic Center. Office Hours are Monday through Friday 8:00a.m. to 4:00p.m. (closed daily for lunch, 12:00 to 1:00).