West Orlando Internal Medicine
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MEDICAL RECORDS RELEASE FORM

HIPAA COMPLIANT **AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION**

Records to be released from:_____
(Doctor or Facility Name)

Fax Number: (____) ____-_____ Phone Number:(____) ____-_____

Patient Name: _____ (Please Print)

DOB: ____/____/_____ Social Security Number: * - ** - _____ (last four ONLY)**

I authorize and request the disclosure of all protected information for purpose of review and evaluation from the above-named doctor or healthcare provider to:

Requesting Provider: *Dr. Osama Ansari, MD*
Requested Information (if more than 25 pages please mail) **Dates - From: _____ to _____**

- ❏ All Records
- ❏ Office/ Consult Visit Notes - Last 2 only
- ❏ Lab Reports Only
- ❏ Radiology Reports Only
- ❏ Cardiology Reports Only
- ❏ Hospital Records- (To include) H&P, Discharge Summary, Labs, All Consult Notes, Any CT Scans- X Rays- MRI's- Medication Reconciliation.
- ❏ Alcohol/ Drug Abuse Information/ HIV Testing/ ARC and/or AIDS diagnosis
- ❏ Other

  _____
  _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I understand the following

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance to this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ _____
Signature of Patient or Legal Authorized Representative Date

_____ _____
Name of Legally Authorized Representative for Patient Relationship to Patient