AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____

Maiden / Other Name _____ Date of Birth _____/_____/_____

Social Security # _____-____-_____ Phone Number: _____

Patient Address:

_____ Street

City State Zip

I authorize: _____ Healthcare facility / physician to release information contained in my medical record

Release information to: iPerformance Center, 200 Calusa Blvd, Suite 300, Destin, FL 32541

Office: 850-460-2024 / Fax: 850-460-7987

Date(s) of Treatment: _____

Specific Type of Information to be Disclosed

☐ Discharge Summary ☐ X-Ray Reports ☐ED Reports

☐ History & Physical ☐ X-Ray Images / CD

☐ Consultation ☐ Operative Reports

☐Other(specify): _____

Method of Disclosure

☐ Paper

☐ CD/DVD format, where available

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ ___/___/_____

Signature of Patient / Parent / Personal Representative Date

If you are signing as a parent, guardian, or personal representative of the patient, describe this relationship and the source of your authority to sign this form below.

_____ Relationship to Patient Print Name