Archangel Michael Health

Authorization to Release or Obtain Medical Records

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1. Patient Information

FULL NAME | DATE OF BIRTH | PHONE NUMBER | LAST 4 OF SSN (OPTIONAL)

DATES OF SERVICE REQUESTED — SPECIFY "ALL DATES" OR PROVIDE A DATE RANGE

2. Release Records — From / To

FROM:

FACILITY/PROVIDER NAME & ADDRESS | PHONE | FAX

TO:

RECIPIENT NAME & ADDRESS

CITY, STATE, ZIP | PHONE | FAX | EMAIL (IF APPLICABLE)

> **To send records to us, use:** Archangel Michael Health, PA (Dr. Bray); 9200 NW 39th Ave, Ste 130-3317, Gainesville, FL 32606 · Phone: 352-441-9110 · Fax: 352-441-9114 · HIE/Direct: christopher.bray.1@33159.direct.athenahealth.com

3. Purpose, Delivery & Expiration

Purpose of Disclosure: ☐ At the request of the individual ☐ Other (specify):

Delivery Method: ☐ Paper/Fax Copy ☐ Electronic Media ☐ Encrypted Email ☐ Unencrypted Email *(I understand the privacy risks — unencrypted email can be intercepted or misdirected)*

Expiration: ☐ This authorization expires **180 days from the signature date** unless specified:

Expiration Date _____ or Event _____

4. Special Cases

USCDI Release (if applicable): Includes Sensitive Information (alcohol/drug abuse, genetic testing, psychiatric, HIV/AIDS).

IF EXCLUDED, SPECIFY

_____

5. Information to Be Disclosed

☐ **All Pertinent Records** (includes items below unless specifically excluded)

☐ Consultation	☐ Operative Report	☐ EKG Report	☐ Problem List
☐ Discharge Summary	☐ Pathology Report	☐ History & Physical	☐ Radiology Report
☐ Medication List	☐ ER Report	☐ Lab Report	☐ Progress Notes

☐ Other (specify): _____

6. Understanding & Acknowledgments

1. I understand that by signing this form, I am authorizing **Archangel Michael Health, PA** to release or obtain my medical records as indicated above.
2. This authorization is voluntary and not required for treatment.
3. I may revoke this authorization in writing at any time, except for actions already taken.
4. Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA.
5. I may be charged a reasonable fee for records per state and federal guidelines.
6. I have the right to receive a copy of this signed authorization upon request.
7. This Practice does not use or disclose PHI for marketing purposes or in exchange for remuneration (sale of PHI).

7. SIGNATURE

I have read and understand the terms of this Authorization. I hereby voluntarily authorize the use or disclosure of my health information as described above.

_____ _____

PATIENT/REPRESENTATIVE SIGNATURE DATE

_____ _____

PRINTED NAME RELATIONSHIP (IF NOT PATIENT)

If signed by someone other than the patient, please provide documentation proving legal authority (Power of Attorney, legal guardian, etc.).

For Practice Use Only · Received By: _____ Date: _____

Verification/ID: _____