ASEDA
Medical Center

Authorization to Obtain, Release or Review Protected Health Information (PHI)

_____ _____
(Print Name) (DOB)

Hereby authorize Aseda Medical Center
Please check one:

- ☐ to obtain from Dr. _____ Fax: _____
- ☐ to release to Dr. _____ Fax: _____
- ☐ to release to me, Home Address: _____

Aseda Medical Center (727) 624-0144
(Name of Doctor) (Phone Number)

112710 STARKEY RD LARGO, FL 33773 (877) 673-7472
(Address) (Fax number)

- ☐ All medical information and reports.
- ☐ Prenatal medical records.
- ☐ Physical examination reports.
- ☐ Laboratory reports.
- ☐ Immunizations.
- ☐ Radiology reports and images.
- ☐ Sexually transmitted disease. reports.
- ☐ Psychiatric/Psychological reports.
- ☐ HIV/AIDS test results.
- ☐ Other (please specify).

Please specify anything that you do **NOT** want to be released: _____
_____

The purpose of the release of information: Continuation of Care_____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results. I expressly consent to the release of information as designated above.

I understand this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this form, there is a processing period of **7–10 business days.**

Patient/Legal Representative or Parent/Legal Guardian Date

_____ _____