AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: ______________________________ Phone: ________________ DOB: __________________

Address: _________________________________ City: ________________ State: _____ Zip: ____________

FROM - Patient authorizes the following facility/provider to disclose information specifically described below:

My Health Onsite Health Center

Facility/Physician: ____________________________ Phone: __________________ Fax: ________________

Address: _________________________________ City: ___________________ State: _____ Zip: _________

Information to be used/disclosed is specifically described below:

Office Notes: Date(s) of Service ____

Diagnostics: Type of Report(s): ____________________ Date(s) of Service: ____________________

Labs: Date(s) of Service: ____

Other (Please specify):_____________________ Date(s) of Service:___________________________

Purpose of Disclosure:

Legal   Insurance   Personal Use   Continued Medical Care   Other (specify)_____

TO - This information may be used and disclosed to and used by the following individual or organization:

Patient

MY HEALTH ONSITE

Physician: ______________________________

Address: ______________________________

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Phone: ______________________________

Fax: ______________________________

Authorization shall expire one (1) year from the date of signature unless otherwise noted here: ____________
(Specify date)

IMPORTANT: By signing below, patient understand this Authorization for Release of Medical Records ("Authorization") should only include medical records dated prior to and including this Authorization. Patient understands this Authorization shall only include medical records originated through MY HEALTH ONSITE (the practice) and/or its affiliates unless otherwise specifically requested. Patient further understands that this authorization is voluntary and may refuse to sign. If patient refuses to sign, patient refusal will not affect patient's ability to obtain treatment from the Practice. Patient understands this Authorization may be revoked at any time by notifying the Practice's Privacy Officer at Medical Risk Solutions LLC dba MY HEALTH ONSITE 2710 Rew Circle, Suite 200, Ocoee, FL 34761. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this Authorization or to the extent this Authorization has been executed as a condition for obtaining insurance coverage. Patient understands the Practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether Patient provides Authorization for the requested use or disclosure.

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Patient/Authorized Representative Signature   Date

Internal Use Only: Reviewed by ______________________on ____________

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