



**CHS Healthcare (Collier Health Services, Inc.)**

1454 Madison Avenue ▪ Immokalee, FL 34142

Phone: (239) 658-3071 Medical Records

Patient Name: \_\_\_\_\_  
Last First MI

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_ Health Record: \_\_\_\_\_

**1 The type and amount of information to be used or disclosed is as follows:**

Date(s) of Treatment: From \_\_\_\_\_ To \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

- Complete record, excluding HIV (AIDS), mental health, and substance abuse information, if any.
- Discharge Summary       Consultations       Laboratory       Immunization Records
- History & Physical       Radiology/ Reports       OB/GYN       Diabetic Information
- Episodic/ Progress Notes       Radiology/ Films       Cardiology/ EKG       Tuberculosis
- Other: \_\_\_\_\_
- HIV/ AIDS \_\_\_\_\_       Mental Health \_\_\_\_\_       Substance Abuse \_\_\_\_\_  
Pt's Initials      Pt's Initials      Pt's Initials

**2 This information for which I am authorizing disclosure will be used for the following purpose:**

- My personal records     Sharing with other health care providers as needed     Other \_\_\_\_\_

**3 I hereby authorize \_\_\_\_\_ to release the above medical information to the following individual or organization \_\_\_\_\_ (address) \_\_\_\_\_ (City/ State) \_\_\_\_\_ (ZIP) \_\_\_\_\_ (Phone) \_\_\_\_\_.**

I understand that this will include HIV (AIDS), mental health, and/or substance abuse test(s) result(s), only if so designated.  
 I further agree to release the above named facility, its affiliates, employees, officers, and physicians from all legal responsibility and liability that may arise from the disclosure and/ or unauthorized redisclosure of such information.  
 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 department. I understand that the revocation will not apply to the information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_.** **If I fail to specify an expiration date, event, or condition, this authorization will expire in one (1) year from the signature date below.**  
 I understand that authorizing the disclosure of this health information is voluntary. I understand that the medical provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.  
 I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.54.  
 If I have questions about disclosure of my health information, I can contact the Health Information Manager or Office Manager.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

*If parent/ Legal Guardian, sign below and state your relationship to the patient. Legal guardian must attach a copy of the document of authority.*

**Signature of Parent/ Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Relationship \_\_\_\_\_

**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO (239) 658-3077**

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**