DIAGNOSTIC CLINIC

(727) 584-7706 www.dc-fl.com

6776 54th Ave. N., Suite A
St. Petersburg, FL 33709
fax: 727-548-9800

630 Pasadena Ave. S.
St. Petersburg, FL 33707
fax: 727-345-7102

1301 2nd Ave. SW
Largo, FL 33770
fax: 727-581-4835

3131 N. McMullen Booth Rd.
Clearwater, FL 33761
fax: 727-726-2563

3820 Tampa Rd. Suite 101
Palm Harbor, FL 34684
fax: 727-785-9660

AUTHORIZATION FOR THE RELEASE OF INFORMATION (Paper Format Only)

Patient Demographic Data

Patient Name: _____ Clinic Record #: _____

Patient Address: _____ Date of Birth: _____

_____ Phone Number: _____

INFORMATION TO BE RELEASED BY: DIAGNOSTIC CLINIC MEDICAL RECORDS DEPARTMENT

PURPOSE OF DISCLOSURE (must complete) ☐ At the Request of the Individual ☐ Continuity of Care

☐ Other (describe) _____

SPECIFIC INFORMATION TO BE RELEASED: _____

_____

SEND INFORMATION TO: (Please be specific)

Provider/Name/Organization _____

Address: _____

Phone #: _____ Fax #: _____

Diagnostic Clinic uses a copy service to process requests and there will be a charge for copying or faxing the requested information. We reserve the right to condition release of the requested information on payment of applicable charges. This form must be received within 6 months of the date that it is signed, and it is valid for 90 days after receipt. It may be revoked at any time upon my written request to the Diagnostic Clinic, unless the requested information has already been disclosed. A fax machine may be used to transmit information, and faxing may increase the risk of accidental disclosure of this information to unauthorized parties. Information released may include but is not limited to alcohol or drug abuse, HIV, mental health, or communicable disease information, which may be part of your health record. Your medical record may contain records from other health care providers. Please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA Rules.

I agree to hold the Diagnostic Clinic harmless and release them from any liability for any claims or actions, which may occur as a result of the release of the information. If I refuse to sign this authorization, my information will not be released except as required by law. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.

Signature: _____ Date: _____

Print Name: _____

If Signed by Representative, Description of Relationship to Patient and Authority: _____

For Clinic Use:

Specific records released: _____ Date: _____

Person sending records: _____ Appt Date: _____

rev. 10.2014

Print Form