

REQUEST TO RELEASE MEDICAL RECORD INFORMATION

REDI-MED
4550 Executive Drive #104
Naples, Florida 34119
239-566-1226

I hereby authorize **Redi-Med** to release my protected health information from my medical records including HIV (AIDS) testing, STD's, mental health and/or substance abuse services to the facility listed.

Patient's Legal Name: _____

DOB: _____

Release the information to: _____

Phone#: _____

Fax#: _____

PLEASE DO NOT FAX RECORDS UNLESS OTHERWISE STATED

Please release the following:

History and Physical Exams

Pathology Report

Radiology Tests

Immunizations

Progress Notes

Laboratory Results

Diagnostic Test

Psychiatric/Psychological

Physician Office Notes

Other

As otherwise provided by law such information may not be disclosed without a specific consent. Additionally, I have the right to refuse disclosure, I understand and acknowledge that certain information contained in my medical record require specific authorization for disclosure and except and prevent any other person from disclosing such information. Such information pertaining to treatment for mental or emotional condition, alcohol, drug abuse, or HIV testing or test results, I do hereby agree to release indemnity and hold harmless Naples Community Healthcare System, its officers, directors employees, agents and members of its staff from and against any claims against or liability by it, out of or in connection with the disclosure of medical authorized by me pursuant to this consent.

THIS CONSENT MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT THAT REDI-MED HAS ALREADY TAKEN ACTION IN RELIANCE ON IT. THIS CONSENT AND AUTHORIZATION SHALL AUTOMATICALLY EXPIRE 90 DAYS FROM THE DATE OF THIS CONSENT, UNLESS REVOKED BY THE PATIENT OR THE PATIENTS AUTHORIZED REPRESENTATION PRIOR TO THAT TIME.

Patients Signature: _____

Date: _____

If legal representative, sign below and state relationship and authority to do so.

Legal Representative: _____

Date: _____

Authority/Relationship to patient: _____

