RECORDS RELEASE AUTHORITY

AUTHORIZATION TO SEND MY RECORDS TO LOCICERO MEDICAL GROUP

To: _____(Facility)

Patient Name: _____ Date of Birth:_____
(Patient's Name or Guardian)
SSN#: _____

To Records Custodian:

I hereby request that you release my PHI to:

LoCicero Medical Group
2605 W. Swann Avenue
Suite 600
Tampa, FL 33609

A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from:
_____ All Records

_____ Records From: _____ To: _____
for continuity of care purposes.

I may revoke this authorization form at anytime by notifying the above referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning this form, signed, dated and "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the records custodian before the receipt of my written notice of revocation.

This authorization form expires on _____or when _____ occurs, but not later than one year from the date of signature below.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this authorization form.

I understand that I am not required to sign this authorization form in exchange for the patient receiving treatment from LoCicero Medical Group or _____. I also understand that payment; enrollment in a Health Plan and/or eligibility for benefits will not be conditioned upon my signing this form.

I understand that I may refuse to sign this form.

There is a potential that the PHI may be re-disclosed by the recipient and no longer protected by Federal or State privacy laws.

_____ _____
(Signature or Patient or Personal Representative) (Date of Request)

_____
(Printed Name of Patient or Personal Representative)

_____ _____
(Address) (Witness)

_____ _____
(City, State, Zip Code) (Date)

Patient or Personal Representative given copy of this form _____