ALTAMONTE MEDICAL ASSOCIATES, P.A.

East Orlando Office
1864 N. Alafaya Trail, Suite B, Orlando, FL 32826
407-384-1414 Fax 407-384-1314

Altamonte Springs Office
631 Palm Springs Drive, Suite 117, Altamonte Springs, FL 32701
407-339-5600 Fax 407-339-5602

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

HIPAA Authorization for Use or Disclosure of Protected Health Information

Use this form to authorize Altamonte Medical Associates, P.A. to release records, obtain records, or discuss health information. Complete all applicable sections. A copy of the signed authorization is valid in place of the original.

1. Patient Information

Patient full legal name

Date of birth

Phone number

Street address

City, State, ZIP

Patient ID / MRN (optional)

Email address (optional)

2. Authorization Direction

Check all that apply. The person or organization below is the other party involved in the exchange or discussion.

- ☐ Release records FROM Altamonte Medical Associates TO the recipient below
- ☐ Obtain records FROM the provider below FOR Altamonte Medical Associates
- ☐ Discuss my health information WITH the person or organization below

Person / organization name

Contact person / department

Phone

Fax

Secure email (if applicable)

Mailing address, City, State, ZIP

3. Information Authorized

Check the applicable items and provide a date range whenever possible.

Records from

Records through

- ☐ Entire medical record

- ☐ Office / progress notes
- ☐ Problem, medication, and allergy lists
- ☐ Laboratory and pathology reports
- ☐ Imaging reports
- ☐ Immunization records
- ☐ Referral / consultation reports
- ☐ Billing records
- ☐ Other - describe below

Other records / specific limitations

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4. Specially Protected Information

Include only the categories specifically authorized below. Unchecked categories will not be released unless disclosure is otherwise permitted or required by law.

- ☐ Mental / behavioral health records — Initials: _____
- ☐ HIV / AIDS test results or treatment — Initials: _____
- ☐ Genetic test results or related treatment — Initials: _____
- ☐ Substance use disorder treatment records — Initials: _____

5. Purpose, Delivery, and Expiration

Purpose

☐ Continuity of care / treatment ☐ Personal use ☐ Insurance / disability / legal ☐ Other

Other purpose or additional instructions

Preferred delivery method

☐ Secure electronic ☐ Fax ☐ Mail ☐ Patient pickup ☐ Other

Delivery details / secure email / fax / other instructions

Expiration date

OR expiration event (for example: completion of this request)

6. Patient Acknowledgment

- **Voluntary:** Signing is voluntary. Altamonte Medical Associates generally will not condition treatment, payment, enrollment, or eligibility for benefits on signing, except as permitted by law.
- **Revocation:** I may revoke this authorization in writing at any time. Revocation will not affect information already used or disclosed in reliance on this authorization.
- **Redisclosure:** Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA, although other privacy laws may apply.
- **Understanding:** I understand the information, purpose, recipient, and expiration stated here. I may request a copy. A photocopy or electronic copy is as valid as the original.

By signing below, I confirm that I have read and understand this authorization and that the information provided is complete and accurate.

7. Signature

Patient or authorized representative - printed name

Date

Time (optional)

Signature - sign by hand after printing or use your PDF application's signature tool

Relationship / legal authority (if applicable)

Description of representative authority (if applicable)

Copy requested? Yes / No