Mid-Florida Surgical Associates

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Medical Records Release

Authorization for use or disclosure of Protected Health Information

Patient Name: _____ Last 4 digits of SS#: _____
Date of Birth: _____ Phone: _____

Disclose/Release the following information (circle applicable):
Complete Records Operative Report/Path Report Rad/Diagnostics Other_____

The purpose for the release of information at the request of the individual is:
Personal Use Continued Treatment Insurance Other_____

AUTHORIZATION FOR MFSA TO **RELEASE** RECORDS

I authorize Mid-Florida Surgical Associates to release the above information to:
___10000 West Colonial Drive, Suite 288, Ocoee, FL 34761 Ph. 407.521.3600 Fx. 407.521.3603
___1804 Oakley Seaver Drive, Suite A, Clermont, FL 34711 Ph. 352.243.2622 Fx. 352.243.6277
___17000 Porter Road, Suite 209, Winter Garden, FL 34787 Ph. 407.521.3600 Fx. 407.521.3603

Doctor, Facility or Personal Use we are releasing records **TO**: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing disclosure of this information. We are only allowed to release our office notes. Operative and path reports must be obtained from the hospital.

AUTHORIZATION FOR MFSA TO **OBTAIN** RECORDS

Doctor or Facility we are receiving records **FROM**: _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Please release the above information to Mid-Florida Surgical Associates:
___10000 West Colonial Drive, Suite 288, Ocoee, FL 34761 Ph. 407.521.3600 Fx. 407.521.3603
___1804 Oakley Seaver Drive, Suite A, Clermont, FL 34711 Ph. 352.243.2622 Fx. 352.243.6277
___17000 Porter Road, Suite 209, Winter Garden, FL 34787 Ph. 407.521.3600 Fx. 407.521.3603

I understand this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has been already taken on this authorization. I understand my protected health information will be used or disclosed by signing this authorization. I understand that I can receive a signed copy of this form. The authorization will expire in one year if no expiration date is specified.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

I wish to revoke this authorization Signature: _____ Date: _____