DIAGNOSTIC CLINIC MEDICAL GROUP
Your Home for Comprehensive Care

Health Information Management Dept.
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AUTHORIZATION FORM FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS

Please check (✓) the appropriate box(es) (☐) and fill in the blanks or your request may be delayed.

1. Patient last name: _____ First name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Clinic record #: _____ Phone number: _____

2. Requesting information from (specify DCMG provider): _____

3. Date(s) of treatment: ☐ Specific dates: _____ through _____

4. Specific information requested *(check all that apply)*:

☐ Abstract report (all pertinent information) ☐ Radiology/Imaging reports (specify): _____
☐ History & Physical ☐ Laboratory reports
☐ OV/Progress notes ☐ Other: _____

5. In what format would you like to receive your records? *(choose one)*:

☐ Paper ☐ CD ☐ Email _____
email address (only for emailed records)

Purpose of Disclosure (*must complete*):

☐ Personal ☐ Continuity of Care
☐ Other: _____

☐ Please send copies of my records to:

Individual / Provider / Personal Representative name: _____
Street address: _____
City, State, ZIP code: _____
Provider phone number: _____
Provider fax number (print clearly): _____

Email is not a secure means of communication. We will encrypt email communications of your records.

DCMG may charge a fee for copies of requested health information to cover the cost of labor, supplies, and/or postage as defined by Florida State Statute 395.3025. We reserve the right to condition release of the requested information on payment of applicable charges. We will inform you of the total charges before providing the requested copies. We will respond to your request within 30 days from the date of receipt. Actual turnaround time is typically shorter. We will require an additional 30 day extension if your health information is not readily accessible or is maintained in an offsite storage facility. We will notify you if we need this extension of time.

If I submit this access request form and request to have my information sent to a third party, I understand that information contained in my medical record may contain HIV/AIDS testing, results, and/or treatment records; mental health diagnosis and/or treatment records; alcohol and/or drug diagnosis and/or treatment records.

This authorization is valid up to 90 days from date of signature but can be revoked at any time by written request. I agree to hold Diagnostic Clinic Medical Group harmless and release them from liability for any claims or actions, which may occur as a result of the release of my 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 of patient/Legal Guardian/Personal Representative — Date

_____ _____
Print name — If signed by Personal Representative, relationship to patient