



Authorization For Release of Protected Health Information

200 East Sheridan Road  
Melbourne Florida 32901  
(321) 725-4500 Ext 307 (321) 724-8069 fax

**PLEASE PRINT CLEARLY**

Full Name: \_\_\_\_\_

MRN#: \_\_\_\_\_ (For Clinic Use Only)

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City : \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home): (\_\_\_\_) \_\_\_\_\_ (Work): (\_\_\_\_) \_\_\_\_\_

I, the undersigned, authorize and request **Melbourne Internal Medicine Associates** to:

**Please Check One:** \_\_\_\_\_ **Release to:** \_\_\_\_\_ **Obtain From:**

Person/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

The Protected Health Information may be used or disclosed for the following purposes:  
\_\_\_\_ Healthcare \_\_\_\_ Insurance \_\_\_\_ Legal \_\_\_\_ Personal \_\_\_\_ Other

**Please Check One:** \_\_\_\_\_ **Mail** \_\_\_\_\_ **Fax** \_\_\_\_\_ **Will Pick-up**

Please copy the following information from my medical records for care and/or treatment that I received from the dates of service : \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_ **All** MIMA records

\_\_\_\_\_ **All** Outside Records

**OR**

\_\_\_\_\_ Cardiology Reports **Only**

\_\_\_\_\_ Laboratory **Only**

\_\_\_\_\_ Radiology Reports **Only**

Specific Records **Only**: \_\_\_\_\_



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\*\*Medication Application

Information: \_\_\_\_\_

Please do **NOT** release the following:

- ◆ Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment and/or examination related to mental health related care, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.
- ◆ By signing this release, you understand that this authorization will remain in effect for 90 days or until revoked in writing (whichever transpires first). MIMA is authorized to use outside vendors for the purpose of copying and providing the information requested.
- ◆ I understand that the state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that MIMA cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.
- ◆ I understand I have the right to inspect and obtain a copy of any information disclosed.
- ◆ I hereby release MIMA and its employees from any and all liability that may arise from the release of information as I have directed.
- ◆ I understand that if I have requested duplication of records within a one year time period (of the same or similar records), I may be charged a fee of up to \$1.00 per page for every page copied. This fee may be waived for copies provided to a health care provider, insurance company or other specific organizations for treatment, billing or operations purposes.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**REQUEST FOR MEDICAL RECORD OF MINOR PATIENT:**

Authorization for the release of medical records must be provided by the parent or legal guardian of the minor patient.

If the parents are divorced, the custodial parent must authorize the release of medical records. If the parents have joint custody, then either parent may authorize the release of medical records.

Check One: \_\_\_\_\_ Parent

If parents are divorced, or if a court has entered a custody order for the minor patient, please check one.

\_\_\_\_\_ Sole custody; Enter name of custodial parent

\_\_\_\_\_

\_\_\_\_\_ Joint custody.



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\_\_\_\_\_ Legal guardian (a legal guardian must present an order of appointment, signed by a judge, granting to him/her guardianship of the minor patient.

\_\_\_\_\_  
Signature of Requesting Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness

Request Processed by: (initials) \_\_\_\_\_ Date: \_\_\_\_\_

Copied date: \_\_\_\_\_