



1223 Gateway Drive • Melbourne • Florida • 32901
321-725- 4500 ext.7307 Fax # _____

Authorization For Release of Protected Health Information For Minors 12-18

(PLEASE ALLOW 7 TO 14 BUSINESS DAYS TO PROCESS)

Requesting Physician: _____ MRN#: _____

Patient's Full Name: _____ DOB: ____ / ____ / ____

(Please print clearly)

Phone: (Hm) () _____ (Wk) () _____ (Cell) () _____

Can leave voice message on: Home phone ____ Work phone ____ Cell phone ____

Address: _____

City: _____ State: ____ Zip code: _____

Check one: Mail copies ____, Mail CD ____, Fax to: () _____

Myself or representative: _____ to pick up **Copies** ____ or **CD** ____

****Records pick up at 1223 Gateway Drive, Melbourne *(records will be held for only 14 days)***

I, the undersigned, authorize and request **Melbourne Internal Medicine Associates** to copy or request the following information from my medical record(s) for care and/or treatment that I receive from the dates of service:

_____ thru _____ / Present

Specific records only _____ All MIMA records _____

Please **do not release** the following: _____



Release to: MIMA _____, Patient/self/person _____, Facility/office/person below _____

Obtain records from facility/office noted below _____

Person/Organization/ Physician _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____ Less than 25 pgs. to be faxed: () _____

The Protected Health Information may be used or disclosed for the following purposes:

Healthcare _____, Insurance _____, Legal _____, Personal _____, Other _____

Authorization For Release of Protected Health Information For Minors 12-18

- **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 180 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 of **over** 12 yrs: _____ Date: _____

Signature of legal guardian / parent: _____ Date: _____

***A photo ID must be provided for proof of identity or release must be notarized.**

Empowered Representative: _____ Date: _____

***Must provide POA or supporting documentation as personal representative or healthcare surrogate.**

Relationship to patient: _____

Witness: _____ Date: _____



 **Staff use only**

ID checked, YES / NO Request processed by: (initials) _____ Date: _____

Modified 05/10