Gilbert Medical Group
3868 Sheridan Street, Suite A, Hollywood, FL
Phone: 954.962.2309 / Fax: 954.842.4590
Email: frontdesk@familydoctortoday.com

Authorization for Disclosure of Health Information/ Release of Medical Records

Patient's Information:

Patient's Name: _____

Date of Birth: _____ Phone:_____

Address: _____

City: _____ State: _____ Zip:_____

- *I authorize the use or disclosure of the above named individual's health information as described below.*
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

  _____ Complete health records _____ Lab results/X-ray reports _____ Consultation Reports

  _____ Other (please specify:_____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

  This authorization will expire on the following:

  Date:_____ Doctor:

  _____

  _____

  _____

  _____

- Gilbert Medical Group is requesting this information to be released for the purpose of Continuation of Care.

Name: GILBERT MEDICAL GROUP INC.

Address: 3868 SHERIDAN STREET SUITE A HOLLYWOOD, FL. 33021.

FAX: 954-842-4590 EMAIL: FRONTDESK@FAMILYDOCTORTODAY.COM

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from today. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of patient or legal representative Signature of witness

Date:_____ Date: _____