C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Authorization for Release of Medical Records

Service Area	☐ **Medical** ☐ **Dental** ☐ **Women's Health** ☐ **Behavioral Health**				
Patient's Name		*Date of Birth*		*Medical Record #:*	
Address					
Address		*Phone #:*			
Verification of Identity (Government Issued Identification – e.g. Driver's License Number & Expiration Date)					

By signing this form, I authorize the following: **Date Ranges: _____ to _____**

Disclosure of the patient's PHI from:		**Disclosure of the patient's PHI to:**	
Person, class of person, and/or organization		Person, class of person, and/or organization	
Address		Address	
Fax	Phone	Fax	Phone

The following protected health information may be disclosed: (check appropriate box or boxes)

☐ **Complete Health Record** ☐ **Encounters & Procedures** ☐ **Consultations** ☐ **Imaging Results**
☐ **Medication List** ☐ **Laboratory Results** ☐ **Vaccination History/Records**
☐ **Other** _____

I further authorize the disclosure of the following information, which may be included in the protected health information listed above (Check and initial all that are approved)

☐ Mental Health: _____ *(initial)*	☐ HIV/AIDS: _____ *(initial)*

The purpose of the disclosure is:

I understand that, by federal law, District Clinic Holdings, LLC. d/b/a C. L. Brumback Primary Care Clinics, may not use or disclose protected health information without authorization except as provided in the Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release the C.L. Brumback Primary Care Clinics and its employees from any and all liability that may arise from the release of information as I have directed.
I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.
I understand that I may refuse to sign this Authorization, and that institutions or individual named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.
I understand that I have the right to obtain, upon request, a list of entities to which my information has been disclosed.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.	**Expiration Date or Event:**

I have read and understand the information in this authorization form.

Printed Name and Signature of Patient or Legal Representative	**Date:**
Printed Name and Signature of Witness	**Date:**