CONSENT FOR RELEASE OF MEDICAL INFORMATION AND/OR X-RAY FILMS

Patient Name: ______________________________ SSN# ______________________

D.O.B ___________________ Phone # ______________________

I authorize: _____________________________________ ___ to release copies of my medical records to:

Universal Health Care
PO Box 1964
St. Petersburg FL 33701-1964

Fax: 727-456-6570
Alternate Fax: 727-821-1894
Attention: ______________

A. I authorize release of information for:
- ☐ Medical Care (physicians, etc.)
- ☐ Personal Use
- ☐ Other: Insurance

B. I authorize release of any (refer to section d. if applicable)
- ☐ Entire medical record -OR-
- ☐ Medical records for the specific treatment dates from ___________ to __________.

C. I authorize release of the following portions of my medical record:
(Write your initials beside each area to be included in release)
- ☐ Diagnosis and/or treatment for mental health/rehabilitation (FL Statute 455.241)
- ☐ Diagnosis and/or treatment for alcohol and/or substance abuse (FL Statute 396.112 and C.F.R. 42 Part 2
- ☐ HIV antibody test and/or AIDS diagnosis and/or treatment (FL Statute 381.004)
- ☐ Genetic Testing

D. ☐ I authorize release of X-ray films To: Universal Health Care

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing) I also understand that this authorization will remain in effect for ninety (90) days unless I specify an earlier date here:______

I have carefully read the information above and the attachment that explains my medical record may contain information that is considered "super confidential." I have had the opportunity to ask questions and I request that my records be released as designated.

I understand that re-disclosure of this information to a party other than the one designated above and MAXIMUS Federal Services (Medicare Independent Review entity) is forbidden without additional authorization on my part.

___________________________________ ________________________
Signature of Patient Date

___________________________________ ____
Signature of Witness Relationship to Patient

Medical Records are a *Necessary* part of your appeal.
Please Sign and Return in the Self-Addressed Stamped Envelope

A Medicare Advantage Organization with a Medicare Contract

Thank You!