

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
100 Central Ave. Suite 200
St. Petersburg FL 33701
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
Thank You!**