

# MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to Carlos A. Labrador, M.D.,P.A. and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. Please list at least one healthcare provider.

Dr (s): \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax# : \_\_\_\_\_

Address: \_\_\_\_\_

I further authorize you to provide to and discuss with Carlos A. Labrador, M.D.,P.A. and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

**Release Medical Records To:**  
**CARLOS A . LABRADOR M.D.,P.A.**  
**65 65<sup>TH</sup> ST S**  
**SAINT PETERSBURG, FL 33707**

Patient's Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Which Records?:** All medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports.

**Purpose of Disclosure:** New PCP.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I am not required to sign this Authorization to ensure treatment and I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rule. This authorization shall remain valid for six months from the date signed below.

Any re-disclosure of this information by recipient is not protected under this authorization.

**Patient or Authorized Representative's**

**Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_