Harris Family Medical Center
1800 W Hibiscus Blvd Suite 101
Melbourne, FL 32901
Phone: 321-726-1600 Fax: 321-726-1610

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Due to our EMS please do not fax more than 25 pages at a time.

This form must be completely filled out in order to process the request

Patient Name: _____ DOB: _____

Social Security Number: XXX-XX-_____ Phone: _____

Reason for release: _____ Type of records: _____

Released From:

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Released To:

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I hereby release all medical information, including diagnosis, medical, surgical, laboratory, or radiologic records of any treatments, examinations, or tests rendered to me, to include any Federal or State protected information under Florida Statute 396.459 (9) Psychiatric information, Florida Statute 397.053 and 396.112 Drug and/or Alcohol Abuse information, and Florida Statute 381.609 (2) HIV tests results (AIDS and related conditions).

I understand and direct that this authorization remain in effect for twelve (12) months or until I revoke it in writing. I hereby release the originating office or facility and its employees from any and all liability that may arise from the release of this information as I have directed.

Patient Signature: _____ Date: _____

If not patient: Signature of Empowered Representative: _____ Date: _____

Relationship to patient: _____ Date: _____

Witness: _____ Date: _____

**If patient requests records for their own personal use or records are released to patient, there is a fee of $1.00 per page for the first 25 pages and $0.25 for each additional page after 25, which will be collected when the records are picked up.

Please Allow 7 to 14 Business Days to Process

RECORDS WILL BE PROCESSED IN THE ORDER THAT THEY ARE RECEIVED