Medical Records Release and Authorization

For Use or Disclosure of Protected Health Information

Medverde

Patient's Name _____

SSN _____ Account/Chart # _____

Date of Birth _____ Phone _____

Address _____

This authorization permits *(provider's name)*

_____

with *(address)* _____

_____

and *(phone)* _____

to use or disclose to Dr. Ann-Marie Wong
Medverde, Inc. 375 NE 54th Street, Suite 7
Miami, FL 33137 Phone: (786) 842 7001
Fax : (786) 410 9200

For Record Release or Copies
By signing this authorization, I authorize this party to use and/or disclose certain protected health information (PHI) about me/my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below provided the information has not been released.

Information to be released *These records are for services provided within the past 6-24 months*

- ○ All medical records
- ○ Office notes/Summary - Diagnosis and treatments + medications list
- ○ Laboratory/Pathology Reports
- ○ Pharmacy/Prescription Records
- ○ X-ray/Radiology Reports

My specific authorization is necessary to release information regarding diagnosis and/or treatment of mental health conditions, substance, abuse, and/or HIV/AIDS status. I authorize the release of potentially sensitive information.

- ○ Mental Health (including anxiety and depression)
- ○ Substance Abuse
- ○ HIV/AIDS

Reasons for Request ○ Consultation ○ Transfer of Care

By signing below, I represent that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are not claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that my treatment will not be conditioned on whether I sign this authorization. This authorization shall expire 6 months from the date hereof.

Signature of Patient of Legal Guardian _____ Print Name of Patient or Legal Guardian _____ Date _____