SAINT THOMAS CLINIC, PLLC
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Spring Hill, FL 34609-1000
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MEDICAL RECORDS RELEASE FOR CONTINUITY OF CARE

Patient Name:	**DOB:** **SS#:**
Information Requested From **Name:**___________________________ **Address:** ___________________________ ___________________________ **Phone:** ______________ **Fax:** ______________	**Recipient of Records:** **SAINT THOMAS CLINIC, PLLC** **7056 Mariner Blvd** **Spring Hill, FL 34609-1000**

INFORMATION TO BE DISCLOSED

Description:	**Description:**	**Description:**
☐Medical Records for Continuity of Care ☐Physician Dictated Notes ☐Office Notes & Reports ☐Clinician Office Chart Notes ☐Billing Statements	☐Most recent one year history ☐Entire Medical Record (all info) ☐Transcribed hospital reports ☐Diagnostic imaging/X-Ray Reports ☐Laboratory Reports	☐Alcohol & drug therapy notes ☐Communicable disease(HIV, HBV, TB) ☐Psychotherapy Office Notes ☐Other ____________________ ☐Other ____________________

PLEASE SEND THE FOLLOWING: ☐ Last 3 Progress Notes, Recent Labs, X-Rays, EKG, Testing, Consultations, Medication Sheets & Summary of Care

Purpose of Disclosure:

☐Ongoing Continued Medical Care	☐ Insurance	☐Disability
☐Patient's Request	☐Legal follow-up	☐Personal Information

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), Prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

______________________________ ______________________________
PRINT PATIENT'S NAME **DATE**

______________________________ ______________________________
SIGNATURE OF PATIENT OR LEGAL REPRSENTATIVE **DATE**

______________________________ ______________________________
PRINT NAME OF LEGAL REPRSENTATIVE (if applicable) **DATE**