

**SAINT THOMAS CLINIC, PLLC**

Hany Abskhroun, M.D  
7056 Mariner Blvd  
Spring Hill, FL 34609-1000  
T: (352) 610-4408/ F: (352) 606-3960



**MEDICAL RECORDS RELEASE FOR CONTINUITY OF CARE**

<b>Patient Name:</b>	<b>DOB:</b>	<b>SS#:</b>
<b>Information Requested to be RELEASED To:</b> Name: _____ Address: _____ Phone: _____ Fax: _____	<b>Release of Records From:</b> <b>SAINT THOMAS CLINIC, PLLC</b> <b>7056 Mariner Blvd</b> <b>Spring Hill, FL 34609-1000</b>	

**INFORMATION TO BE DISCLOSED**

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

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

**Purpose of Disclosure:**

<input type="checkbox"/> Ongoing Continued Medical Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Disability
<input type="checkbox"/> Patient's Request	<input type="checkbox"/> Legal follow-up	<input type="checkbox"/> 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.

_____	_____
<b>PRINT PATIENT'S NAME</b>	<b>DATE</b>
_____	_____
<b>SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE</b>	<b>DATE</b>
_____	_____
<b>PRINT NAME OF LEGAL REPRESENTATIVE (if applicable)</b>	<b>DATE</b>