

Clermont Medical Center
.3755 S Hwy US-27
Clermont, FL 34711
Ph: 352-394-4035 Fax: 352-394-8585

Authorization to send or receive medical records

Patient Name: _____ Date of Birth _____

Last 4 of Social Security # _____

I authorize Clermont Medical Center to

Send **Receive** my protected health information **To** **From** the following:
Physician/Person/Facility/Entity and/or those directly associated in my medical care

Facility Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last one year of all my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excluded:

Other: _____

By signing this form, I authorize Clermont Medical Center to send or release confidential health information about myself, by sending or releasing a copy of my medical records, a summary or narrative of my protected health information.

Patient Name or Legal Authorized Individual Signature Date

Printed Name if Signed on behalf of the Patient Relationship (parent, legal guardian, POA)