ORLANDO MEDICAL CENTER

NEIL COSKUN, MD - BOARD CERTIFIED INTERNAL MEDICINE

7800 LAKE UNDERHILL ROAD

ORLANDO, FL 32822

Ph: (407) 282-2244 ◊ Fax: (407) 282-2002

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ , hereby authorize the use or disclose of my individual identifiable health information which include all portions of the medical record including laboratory and radioloy studies. I understand that this authorization is voluntary. I understand that if the organization to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

PATIENT INFORMATION :

NAME: _____ DOB: _____ PHONE: _____

ADDRESS _____ CITY: _____ State /Zip _____

I AUTHORIZE THE RELEASE OF INFORMATION TO :

Orlando Medical Center
Neil Coskun, MD
Board Certified Internal Medicine
7800 Lake Underhill Road
Orlando, FL 32822
PH : (407) 282- 2244
FAX: (407) 282- 2002

MEDICAL RECORDS ARE BEING SENT FROM :

PHYSICAN NAME: _____
PRACTICE NAME: _____
ADDRESS: _____
CITY / STATE / ZIP : _____
PHONE : _____
FAX : _____

This information will be used / disclosed for the following purpose(s) :

___ **Clinical Office Notes** ____ **Lab Reports** ____ **Radiology Reports** ____ **Hospital Records**

___ **All Medical Records** ____ **Stress Test** ____ **2D ECHO / Holter**

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164

A photocopy of this document is as sufficient as the original.

I understand the disclosure of the information in this medical record may include information relating to sexually transmitted diseases, acquired, immunodeficiency sydrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment , treatment for substance abuse, or genetic testing results.

I understand that this authorization will expire in 1 (one) year from the date signed below unless otherwise specified.

I understand that once the information is disclosed, the informed is subject to redisclosure and may no longer be protected by the federal privacy regulations.

This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by contacting Orlando Medical Center in writing , to: Orlando Medical Center, Medical Records Dept, 7800 Underhill Road, FL 32822

I understand the matters discussed on this form. I release the provider, its employees,officers, and directors,medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I understand that Orlando Medical Center will not condition treatment, payment, enrollment or eligibility for benefits on my signing of this authorization.

X _____
Date of Authorization (Required)

X _____
Signature of Patient (Required)

OFFICIAL USE ONLY

RECEIVED BY : _____

PROCESSED BY : _____ **SENT VIA :** MAIL FAX HANDCARRIED