AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
FROM OTHER HEALTHCARE FACILITIES

Patient Name:_____ SS#:_____

Telephone #:_____ Date of Birth: _____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Name of Healthcare Facility from which Records are Requested:

_____ Ph: _____ Fax: _____
(Please Print)
Address:_____ City:_____ State:_____ Zip:_____

Dates of Treatment Requested: _____

Reason for Disclosure: _____

MAIL INFORMATION TO: **OCEAN BLUE MEDICAL RESEARCH CENTER, INC.**
286 Westward Drive, Miami Springs, FL 33166
Or FAX TO: **305.885.8984**

I hereby authorize **OCEAN BLUE MEDICAL RESEARCH CENTER, INC.,** to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Check a Box ☑

	History & Physical		EKGs
	Physical / Occupational Therapy Reports		Radiology Reports
	Laboratory Reports		Pathology Reports
	Other (Specify)		

This consent is subject to revocation at any time except to the extent the action has been taken thereon**. This authorization and consent will expire one year from the date of authorization written below.**

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____/_____/_____
Signature of Patient or Legal Representative

Printed Name: _____ Relationship if not Patient: _____

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.
**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate certificate is required coupled with the documents naming the administrator or executor of the estate.