Rebecca Hunton, MD
Lisa Johnson, PA
150 Fifth Avenue
Indialantic, FL 32903
T 321.254.6803
F 321.254.6819

Authorization to Release Medical Records
Patient Name: _____
DOB: _____
Phone Number: _____

I give authorization for the use or disclosure of the above individual's health information as described:

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____
Address: _____City: _____ State: _____ ZC: _____
Phone: ( ) _____ Fax: ( ) _____

Information regarding person or entity who can receive and use this information:

Name: _____
Address: _____City: _____ State: _____ ZC: _____
Phone: ( ) _____ Fax: ( ) _____

Type of information to be used or disclosed (check all that apply)
o All Medical Records
o Specific Information
o Other

Including any of the following related confidential information (check all that apply)
o HIV/AIDS
o Mental Health
o Substance Abuse Treatment
o Reportable STD's

Dates of service requested:
o All Medical Records
o Past 12 Months
o Specific time period from _____ to _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records custodian. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition this authorization will expire in 12 months.

I understand that treatment and/or payment is not conditioned upon signing this form.

Signature: _____ Date: _____

Printed Name:_____ Relationship to patient:_____