AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name ____ Date of Birth __________________________
Address ____ City, State, Zip ________________________
Phone Number ______________________________

Purpose of the Release:
□ Copies for own use □ Continuing care
□ Insurance □Legal
□ Other (specify) ___________________________

Method of Delivery:
□ US Mail
□ Fax
□ eDelivery
□ Self pick up

Information to be Released:
Date from: ____________ to: ______________
□ Clinic notes
□ Operative/Procedure notes
□ Billing records
□ Lab/pathology reports
□ Radiology reports/images
□ Entire medical record
□ Other record (specify below)
____

*Reasonable charges will apply for copy services.

Information to be Released to:
Organization/Person ____
Address ____ City, State, Zip _______________________
Phone Number ___________________________ Fax Number __________________________

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that Argus Dental & Vision, Inc. ("Argus") will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document. I understand that authorization covers records relating to communicable diseases, AIDS/HIV treatment, behavioral/mental health care, alcohol and/or drug abuse treatment, and genetic testing if any such record exists.

I understand that I have the right to revoke this authorization at any time except to the extent that Argus has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Argus Dental & Vision, Inc., Attention: Compliance Department, 4919 West Laurel Street, Tampa, FL 33607. I understand that the revocation will not apply to information that had already been released in response to this Authorization.

I understand that I may inspect or request copies of any information disclosed by this authorization.
I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information. I understand that this authorization will expire one (1) year from the date of signing unless specified below:
Desired Expiration Date __________________________________

____ ______________________________________
Signature of Patient or Authorized Legal Representative Date

____ ______________________________________
Print Name Relationship to Patient (if not patient)

If you are signing as a personal representative, please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the member signed above.