Clermont Medical Center
BOARD CERTIFIED FAMILY PHYSICIANS
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 # _____

☐ **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: _____

☐ 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 excepted: _____

☐ 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)