Clermont Medical Center
1135 Lake Ave.
Clermont, FL 34711
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 #_____

I authorize Clermont Medical Center to
o **Send** o **Receive** my protected health information o**To** o**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:_____

o**Last one year** of 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 excluded:

o **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)