TEENA HUGHES MD PA
4444 E FLETCHER AVE STE C
TAMPA, FL 33613

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I HEARBY AUTHORIZE:

Previous Physician/ Facility: _____
Address: _____
Phone# _____ Fax#_____

To Release From The Health Records Of:

Patient Name: _____Date of Birth:_____
Social Security Number: _____Daytime Phone: _____
Are you authorizing the release of your own records? ___Yes ___ No
If not, what is your name and relationship to the patient?
Name: _____Relationship:_____

Release of certain medical information requires minor's consent. This applies to persons age 13 to 17 for information pertaining to substance abuse and mental health information, or persons age 14 to 17 for information pertaining to sexually transmitted diseases, HIVand AIDS. Other laws may apply.

(RELEASE ALL THAT APPLY)
____ COMPLETE MEDICAL RECORDS
___Specific: Chart Notes: _____ Date of Treatment:_____
___ IMMUNIZATION RECORDS

To Be Released To:

TEENA HUGHES MD PA
4444 E FLETCHER AVE STE C
TAMPA, FL 33613
PH# (813)903-0060 FAX#(813)903-1773

For The Purpose Of: (Please check all that apply)

_____ Transfer of Care
_____At My Request
_____Other: _____

My Rights:

- I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
- I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment).
- Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (Please check or circle all that apply to **EXCLUDE** the information from authorization):

Substance Abuse Mental Health Conditions Sexually Transmitted Diseases HIV/AIDS

- I understand once Teena Hughes MD has released my health care information to the above named entity, the person or organization that receives it may re-disclose the information and that it may no longer be protected by privacy laws.
- I understand release of my records may take up to 15 working days.

I have read the above Authorization to Release Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____Date:_____
Signature of Patient or Parent/ Legal Guardian