OFMC
OCALA FAMILY
MEDICAL CENTER

Ocala Family Medical Center
2230 SW 19th Avenue Road
Ocala, FL 34471
Phone: (352) 237-4133
Fax: (352) 873-4581

Patient Name: D.O.B: Last 4 SSN# _____

Address:

I hereby request and authorize: **Ocala Family Medical Center** to:

☐ **Send Records TO:**

☐ **Obtain Records FROM:**

Name: _____

Address: _____

Phone: _____ Fax: _____

The type and amount of information to be used or released is as follows:

☐ **Office Visit Notes** ☐ most recent note or ☐ ___ year(s) of notes or ☐ From Dates:_____to_____

☐ **Labs / Pathology** ☐ most recent labs or ☐ ____ year(s) of labs or ☐ From Dates:_____to_____

☐ **Cardiac Reports** Test Type:_____From Date:_____to_____

☐ **Radiology Reports** Test Type:_____From Date:_____to_____

☐ **Radiology Images on CD:** Test Type:_____From Date:_____to_____

☐ **Other:** _____

Via: ☐ In office pick-up ☐ Fax ☐ PDF file through Secure Messaging on Patient Portal

For the purpose of: ☐ Transferring Care ☐ Continuity of Care ☐ Personal

_____ _____/_____/_____

Patient / Legal Representative Signature **Date**

I understand that these records include diagnosis, treatment, and/or examination related to my health care and may include information related to drug/alcohol abuse, mental health, HIV testing, and sexually transmitted disease when applicable. I understand that state law prohibits the re-disclosure without further consent. I understand this release will remain in effect for (1) year or until I revoke it in writing. I understand that I have a right to inspect and obtain a copy of all information released. I authorize Ocala Family Medical Center to release all information in a paper form or by electronic media. I release Ocala Family Medical Center and its employees from any and all liability that may arise from release of information as I have authorized. Signature on this authorization or refusal thereof will not have any effect on treatment at Ocala Family Medical Center. I understand that I may be charged up to $1.00 per page for every page copied or $10.00 for a single CD containing the information. This fee is waived for copies provided for continuity of care. Records can be received and sent electronically by the use of the XML standard Continuity of Care Record (CCR) or Continuity of Care Document (CCD). These records may be sent and received by CD, or Email.

Office use only: Requesting Provider/MA _____

Completed By: _____ Faxed By: _____ Date: _____

☐ Task sent to Film for CD of Radiology Images ☐ Task sent for Hospital Records (Advent Health, Timberidge, ORMC, West Marion)