



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: \_\_\_\_\_

Address: \_\_\_\_\_

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

Name: \_\_\_\_\_

Send Records TO:

Address: \_\_\_\_\_

Obtain Records FROM:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Office Visit Notes All or most recent note or year(s) of notes or From Dates: to

Labs / Pathology All or most recent labs or year(s) of labs or From Dates: to

Cardiac Reports Test Type: From Date: to All

Radiology Reports Test Type: From Date: to All

Radiology Images on CD: Test Type: From Date: to All

Entire Record or year(s) or 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: \_\_\_\_\_ Date: \_\_\_\_\_

Task sent to Film for CD of Radiology Images

Task sent for Hospital Records (Advent Health, Timberidge, ORMC, West Marion)