



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth _____
Address _____ City, State, Zip _____
Phone Number _____

Purpose of the Release: <input type="checkbox"/> Copies for own use <input type="checkbox"/> Continuing care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Other (specify) _____
Method of Delivery: <input type="checkbox"/> US Mail <input type="checkbox"/> Fax <input type="checkbox"/> eDelivery <input type="checkbox"/> Self pick up

Information to be Released: Date from: _____ to: _____ <input type="checkbox"/> Clinic notes <input type="checkbox"/> Operative/Procedure notes <input type="checkbox"/> Billing records <input type="checkbox"/> Lab/pathology reports <input type="checkbox"/> Radiology reports/images <input type="checkbox"/> Entire medical record <input type="checkbox"/> Other record (specify below) _____
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*Reasonable charges will apply for copy services.

Information to be Released to:
Organization/Person _____
Address _____ City, State, Zip _____
Phone Number _____ Fax Number _____

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that Argus Dental & Vision, Inc. ("Argus") will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document. I understand that authorization covers records relating to communicable diseases, AIDS/HIV treatment, behavioral/mental health care, alcohol and/or drug abuse treatment, and genetic testing if any such record exists.

I understand that I have the right to revoke this authorization at any time except to the extent that Argus has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Argus Dental & Vision, Inc., Attention: Compliance Department, 4010 West State Street, Tampa, FL 33609. I understand that the revocation will not apply to information that had already been released in response to this Authorization.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information. I understand that this authorization will expire one (1) year from the date of signing unless specified below:
Desired Expiration Date _____

Signature of Patient or Authorized Legal Representative Date

Print Name Relationship to Patient (if not patient)

If you are signing as a personal representative, please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the member signed above.