Crystal Community ENT & Facial Plastic Surgery
Dr. Denis Grillo, D.O., F.O.C.O.O.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the following protected health information to be released from the medical record of:

Patient's Name: _____
Last First Middle

Soc. Sec. #: **xxx-xx-**_____ Date of Birth: _____ Telephone #: _____

RELEASE RECORDS:

☐ **TO**
☐ **FROM**

Crystal Community ENT/Dr. Denis Grillo
790 SE 5th Terrace
Crystal River, FL 34429-4852
Phone:(352) 795-0011
Fax:(352) 795-9481

☐ **TO**
☐ **FROM**

Name/Organization: _____
Address: _____
City: _____ **St:** ___ **Zip:** _____
Phone: _____
Fax: _____

☐ **Please fax my records** ☐ **Please mail my records** ☐ **Please call when my records will be ready to pick up**

REASONS FOR RELEASE OF INFORMATION

Purpose of release (*for example: continued care, personal, etc.*): _____

Needed for doctor's appointment on: _____
(Date) (Time)

INFORMATION TO BE RELEASED

☐ **Entire Record**

☐ **Specific information desired:** _____

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmissible diseases.
As required by state and federal law, Crystal Community ENT may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.
I understand the state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Crystal Community ENT cannot guarantee that the recipient or the information will not re-disclose this information contrary to such prohibition.
I understand that this authorization will remain in effect for one (1) year or until expiration date of this authorization. I can also revoke it in writing to, Crystal Community ENT, 790 SE 5th Terrace, Crystal River, Florida 34429. I further understand that any such revocation does not apply to information already released in response to this authorization.
I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.
I understand that I have a right to inspect and to obtain a copy of any information disclosed.
I hereby release Crystal Community ENT and its employees from any and all liability that may arise from its release of information as I have directed.
I understand that I may be charged a fee of up to $1.00 per page up to 25 pages and .25 for additional pages (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical care.
I understand that this fee is within the limits allowable by Florida law.
Expiration of release effective (1) one year from date signed or specified date of : _____
I herby authorize Crystal Community ENT to release health information as described above.

Patient's Signature: _____ Witness: _____

Signature of Parent or Guardian: _____ Date: _____

Relationship to Patient: _____