Prompt Primary Care of Ocala
8750 SW SR 200 Ste 102
Ocala, FL 34481
Tel: 352-861-5444 Fax: 352-861-5447
CELESTINO D. SANTI, DO DIANNE G. COPENHAVER, ARNP
MICHAEL REILLY, ARNP

Authorization for use of or disclosure of protected health information

I, _____ authorize Prompt Primary Care of Ocala and its affiliates, employees or agents to:

Obtain Records from _____ Phone/Fax _____
Name of doctor or healthcare facility

Address _____

Release Records to PROMPT PRIMARY CARE OF OCALA Phone/Fax 352-861-5447
Name of doctor or healthcare facility

Address: 8750 SW STATE ROAD 200 SUITE 102, OCALA, FL 34481

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is attained, except to the extent that action has already been taken on this authorization. Mental Health, Alcohol, Drug, HIV and/or AIDS information is confidentially protected by Federal & State Law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/texting information in the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized redisclosure of my health information.

Information to e released or obtained: The privacy law requires you to initial by each item that applies:

_____MENTAL HEALTH _____PSYCHOTHERAPY NOTE _____HIV TESTING

_____AIDS INFORMATION _____DRUG and/or ALCOHOL _____GENETICS

The specific records to be released or obtained are: INITIAL ITEM THAT APPLIES AND SPECIFY TIME FRAME TO BE SENT:

_____COMPLETE RECORD From_____to_____ OR ☐ Last Hospital Visit (Complete Record)

_____ALL DIAGNOSTIC TESTING From_____to_____

_____PATHOLOGY/OPERATIVE From_____to_____

_____LAB RESULTS ONLY From_____to_____

_____OTHER (PLEASE SPECIFY) From_____to_____ (_____)

SIGNATURE_____TODAY'S DATE_____

SOCIAL SECURITY_____DATE OF BIRTH_____

ADDRESS_____

WITNESS_____