MD Now Medical Centers internal use only:	
Records Released by:	
Office Location:	
Charge amount:	$
Fax to H.I.M. by:	
D.O.S. From-To:	/ / - / /

Lake Worth: 4570 Lantana Rd. Lake Worth, FL 33463 Phone: 561-963-9881 ☐	**Palm Beach Gardens:** 9060 N. Military Trl. Palm Beach Gardens, FL 33410 Phone: 561-622-2442 ☐
Boca Raton: 7035 Beracasa Way Ste 105 Boca Raton, FL 33433 Phone: 561-361-1515 ☐	**Royal Palm Beach:** 11551 Southern Blvd. Ste 4 Royal Palm Beach, FL 33411 Phone: 561-798-9411 ☐
Boynton Beach: 2272 N. Congress Ave. Boynton Beach, FL 33426 Phone: 561-737-1927 ☐	**West Palm Beach:** 2007 Palm Beach Lakes Blvd, West Palm Beach, FL 33409 Phone: 561-688-5808 ☐

Fax / e-mail Medical Records Requests to:
866-708-4298 / mdn-mrd@mymdnow.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I ________________________________, hereon referred to as the Patient, and whose date of birth is _____/______/________, hereby authorize the release and disclosure of medical records and information:

☐ To MD Now Medical Centers ☐ From MD Now Medical Centers

To: Institution, Individual or Agency	From: Institution, Individual or Agency
Street Address:	
City, State, Zip:	
Phone #	Fax #

The question of privacy between the MD Now Medical Centers, Inc., my attending physician, other physician(s), and the patient is waived. I fully understand that my medical record or information maintained in connection with the date(s) of service from inception until today may contain mental health, alcohol and drug abuse history, Human Immunodeficiency Virus (HIV) test results, or Acquired Immunodeficiency Syndrome (AIDS) information. The medical records or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Once this information has been disclosed to the authorized party above, I acknowledge that it may be subject to re-disclosure by the recipient and my privacy may no longer be protected. Only such records or information believed necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the record that are disclosed. If I refuse to sign this authorization, my medical record will not be released.

Information Requested (ALL RECORDS if not specified):____
(Specify type of information)

Purpose of the Request:
This authorization is valid for one year from the date signed or until ___/___/_____. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting revocation request to the Health Information Management department.

Patient/Parental Signature: ____ Date: ______________________

Patient/Parental Print Name: ____

Relationship to Patient: ____ Phone #: ______________________

Proof of Release of Medical Records to patient/third party/legal guardian

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that my records may not have been reviewed by the provider and therefore may not be considered as full and complete records for legal purposes. Should I require a legally verified and complete copy of my records, I will have my physician, legal representative, or attorney; submit a request for such records in writing along with consent for release of records in order to comply with HIPAA regulations.
By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. If I refuse to sign this authorization, my medical record will not be released.

Signature of patient (or patient's personal representative) Date:

Printed name of patient (or patient's representative) Representative's authority to sign for patient, *(parent, guardian, power of attorney for healthcare)*