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MEDICAL RECORDS RELEASE/AUTHORIZATION FORM

DATE: _____

TO: _____

ATTN.: MEDICAL RECORDS DEPARTMENT

I AM WILLING TO ALLOW A PHOTOSTAT OF THIS AUTHORIZATION TO BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

PLEASE MAIL TO ASSENT MEDICAL COST MANAGEMENT, INC. A COPY OF MEDICAL RECORDS CONSISTING OF:

- EMERGENCY ROOM RECORDS
RECOVERY ROOM RECORDS
ANESTHESIOLOGY RECORDS
NURSNG MEDICATION NOTES
MEDICATION ADMIN. RECORDS
OPERATING ROOM RECORDS
NURSING NOTES
PHYSICIAN'S ORDERS
DISCHARGE SUMMARY
OTHER

PERTAINING TO HOSPITALIZATION FROM _____ 20__ TO _____ 20__.

PATIENT NAME

DATE OF BIRTH

PATIENT ACCOUNT NUMBER

SOCIAL SECURITY NUMBER

ADDRESS

CITY/STATE/ZIP

NOTE: PRIOR APPROVAL OF CHARGES MUST BE OBTAINED IF FEES EXCEED A REASONABLE CHARGE OF 50 CENTS A PAGE FOR UP TO FIFTY PAGES AND 25 CENTS A PAGE THEREAFTER, AND A FEE FOR SEARCHING, HANDLING, AND MAILING THAT DOES NOT EXCEED TEN DOLLARS.

SIGNED

DATE OF SIGNATURE

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to the individual(s) designated on this release form. This protected health information is to be disclose under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I acknowledge that I have received a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the Company.

- This release will remain in effect and valid for 90 days from date of signature