CENTER FOR COUGH
MANDEL SHER, M.D.

11200 SEMINOLE BLVD., SUITE 310, LARGO, FLORIDA 33778
Phone: (888) 632-6844 Fax: (727) 397-4459

MEDICAL RECORDS REQUEST AUTHORIZATION

I hereby authorize the release of my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

Requesting records From:_____
(Name of Facility or Physician to provide records)

Address:_____Phone:_____ Fax:_____

Send or fax records To: CENTER FOR COUGH
11200 SEMINOLE BLVD., SUITE 310, LARGO, FLORIDA 33778 Fax: (727) 397-4459

INFORMATION TO BE RELEASED:

(Check ALL that apply)	**Date(s)**
__ History & Physical Exam	_____
__ Office Visits Notes	_____
__ Lab Reports	_____
__ X-Ray Reports	_____
__ Other _____	____ _____

I specifically authorize the release of information relating to:
__ Substance Abuse (including alcohol/drug use)
__ Mental Health (including psychotherapy notes)
__ HIV related information (including AIDS related testing
__ Genetic Testing

PURPOSE OF DISCLOSURE:
___ Changing Physicians ___ Consult/Second Opinion ___ Continuing Care ___ Legal
___ Other _____

I understand that I may: 1. Request a copy of this authorization. 2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. 3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request. 4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form. I understand that if the organization that receives the information is not healthcare provider, plan or business associates (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

_____ _____
(Patient's Name) **(Patient's Date of Birth)**

Signed by:_____ _____
(Signature of Patient or Legal Guardian) (Relationship to Patient)

_____ _____
(Print Name of Patient or Legal Guardian) (Today's Date)

This authorization will expire one year from date of authorization or:_____.
{Expiration Date or Defined Event}.