Braden Clinic
5050 Ave Maria Blvd.
Ave Maria, FL 34142
Dr. Beau R. Braden, DO, Dr. Buck A. Braden, DO, Anthony J. Musingo, PA-C, Taresa B. Fassbender, PA-C

Medical Records Request/Release Patient's Name: _____
Date of Birth: _____
Address: _____
City _____ State ___ ZIP_____ Tel: _____
I hereby authorize the use/ access/disclosure/release of my protected health information as describe below: The following organization is authorized to make the disclosure:
(Name of the Facility) _____

Address_____

Tel: _____ Fax: _____

Information to be released or disclosed: ALL Health Records _
This information may be disclosed to and used by the following individual/ organization:
BRADEN CLINIC ~ 5050 AVE MARIA BLVD., AVE MARIA, FL 34142
(239) 867-4395 OFFICE (844) 735-8444 FAX

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

I understand that, per Florida Statutes, I may be charged a fee of up to $1.00 per page (plus sales tax and postage) for every page copied. The fee is waived for copies provided to a health care provider for continuing medical care. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record set you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization. I may inspect or copy any information used or disclosed under this authorization as described above. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ **Signature of Patient**

_____ _____
Name of Patient (Printed) Date

_____ **Legal Representative**

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

_____ _____
Relationship and Legal Authority Date