LINDA MARRACCINI, M.D & JOHN MARRACCINI
6280 SUNSET DRIVE SUITE #407
MIAMI, FL 33143
PHONE # 305-666-8858
FAX # 305-665-1731

AUTHORIZATION REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE _____

STAT PATIENT IN OFFICE!

PATIENT NAME _____

SS# _____ DOB: _____

I HEREBY AUTHORIZE: (NAME & FAX NUMBER)

_____
_____
_____
_____

TO RELEASE MY MEDICAL RECORDS TO: DR. LINDA & JOHN MARRACCINI.

I REQUEST ALL MY MEDICAL RECORDS THAT MAY HAVE BEEN ACQUIRED BY EXAMINATION OR ANY OTHER MEANS, REGARDING MY PHYSICAL OR MENTAL CONDITION. I HEREBY RELEASE THE PHYSICIAN OF ANY CONSEQUENCE PURSUANT TO THIS RELEASE OF RECORDS.

_____
PATIENT NAME (PRINT)

PLEASE FAX RECENT
NOTES, LABS, EKS & IMAGES
THANKS!

_____
PATIENT SIGNATURE

_____
WITNESS

THE ENCLOSED PROTECTED HEALTH INFORMATION IS CONFIDENTIAL IN COMPLIANCE WITH HIPPA REGULATIONS 45 OFR 160-164 AND CAN ONLY BE USED FOR PURPOSE AUTHORIZED. YOU ARE RESPONSIBLE FOR THE SECURITY OF PHI. DO NOT RE-DISCLOSE, COPY OR TRANSMIT THIS INFORMATION TO OTHER PARTIES WITHOUT PRIOR CONSENT OF THE PATIENT. YOU ARE RESPONSIBLE FOR ACCOUNTING OF DISCLOSURE OF PHI, AND AFTER USE ALL COPIES ARE REQUIRED TO BE DESTROYED.

AUTHORIZATION TO RELEASE MEDICAL

INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal Government Privacy rules implemented through the Healthcare Portability Act of (HIPPA), In order for your healthcare provider or staff of Dr. Marraccini's office to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize Dr. Marraccini to release any or all information concerning my medical care to any individual except as set forth above.

_____ I do authorize Dr. Marraccini to verbally release any or all information concerning my medical care to the following individuals:

_____ _____

Name/Relationship to Patient Phone number

_____ _____

Name/Relationship to Patient Phone number

_____ _____

Name/Relationship to Patient Phone number

_____ _____

Name/Relationship to Patient Phone number

_____ _____

Patient or Power of Attorney Signature Date

_____

Print Patient Name

Dr. Linda Marraccini- Dr. John Marraccini