Authorization for Release of Medical Information

1. Select a Clinic Location *(please check one)*:
   - ☐ 5270 Babcock Street NE, Suite 1, Palm Bay, FL 32905……………………………… (Tel): 321-722-5959……… (Fax): 321-241-6890
   - ☐ 775 Malabar Road, Suite 105, Malabar, FL 32950………………………………… (Tel): 321-722-8435………(Fax): 321-241-6890
   - ☐ 17 Silver Palm Avenue, Melbourne, FL 32901………………………………………(Tel): 321-733-2021……… (Fax): 321-241-6890
   - ☐ 220 Barton Blvd, Rockledge, FL 32955……………………………………………… (Tel): 321-639-5177……… (Fax): 321-241-6890
   - ☐ 1537 N Singleton Ave, Titusville, FL 32796……………………….. (Tel): 321-268-0267……… (Fax): 321-241-6890
   - ☐ 2120 Sarno Road, Melbourne, FL, 32935…………………………………………… (Tel): 321-241-6800……… (Fax): 321-241-6890
   - ☐ 7227 N. Highway 1, Cocoa, FL, 32927……………………………………………… (Tel): 321-877-2740……... (Fax): 321-241-6890
   - ☐ BHA Mobile Clinic……………………………………………………………… (Tel):321-914-5864……..(Tel):321-241-6890
   - ☐ 2120 Sarno Road, Melbourne, FL, 32935 Ste 2 (Women's Health)……………… (Tel):321-425-4807…… (Fax):321-241-6890
   - ☐ 1361 Florida Ave NE Palm Bay, FL, 32905…………………………………………(Tel):321-241-6800……..(Fax):321-241-6890

2. Patient Name *(print)*______________________________ Date of Birth *(mo/day/yr)* ________________

   Social Security # : ________________________

3. I Hereby Authorize Brevard Health Alliance *(check one)*:
   ☐ To Send To: ☐ To Receive From:

____
Name of Provider, Facility, or Person

____
Street Address, Suite #, Apt #

____
City, State, Zip Code

____
Phone Number Fax Number

4. The Following Information ***(SIGN YOUR INITIALS)***:

________ All Medical Information and Reports
________ Laboratory Reports
________ Office Visit Reports
________ Drug and Alcohol Abuse
________ Immunizations & Growth Charts
________ Behavioral and Mental Health Services
________ X-Ray/Imaging Reports
________ (STD) Sexually Transmitted Diseases, and (AIDS) Acquired Immunodeficiency Syndrome, and (HIV) Human Immunodeficiency Virus

5. Dates of Service: *(From)*________________________ *(To)* ________________________
6. This authorization will expire in one year from the date signed. Brevard Health Alliance is authorized to use outside vendors for the purpose of copying and providing the information requested. I hereby release Brevard Health Alliance, its employees, vendors, and/or independent contractors from any and all liability that may arise from the release of this information as I have directed.
7. I understand that Brevard Health Alliance does not release medical records received from other physicians, facilities hospitals or emergency rooms. You must request these parties to send your medical records where you want them to go.
8. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Brevard Health Alliance.
9. I understand that the revocation will not apply to any information that has already been released in response to this authorization.
10. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to context a claim under my policy.
11. ______________________________ ____________________
    Signature of Client of Legal Representative Date

    ______________________________ ____________________
    Legal Representative's Relationship to Client Date

12. ***(Use this space only if client withdraws consent)*** ________________________ ____________________
    Signature of Client or Legal Representative Date Consent revoked by Client