Dr. Mark Talbert, General Surgery
129 Hibiscus Blvd , Suite D • Melbourne • Florida • 32901
Phone: 321-372-1372 Fax# 321-369-9247

Authorization For Release of Protected Health Information

(PLEASE ALLOW 7 TO 14 BUSINESS DAYS TO PROCESS)

Requesting Physician ______________________________________: Acct#______________

Patient 's Full Name: ____ DOB: ____/____/_____
(Please print clearly)

Phone: (Hm) ________________ (Wk) _________________(Cell) _______________

Can leave voice message on: Home phone ☐ Work phone ☐ Cell Phone ☐

Address: ____

City: ____ State: ______ Zip code: ______

Please check one: Mail copies☐, Fax to: (___)____________

Myself or representitive ___________________________ to pick up copies

I, the undersigned, authorize and request **Dr. Mark Talbert to** copy or request the following information from my medical record(s) for care and/or treatment that I receive from the dates of service: ________ to _________

Specific records only:____

Please ***do not release*** the following: ____

Release to: Dr. Talbert ☐, Patient/self/person ☐, Facility/office/person below ☐

Obtain records from facility/office noted below ☐

Person/Organization/ Physician ____
Address: ____
City: ____________________________ State: ________ Zip Code: __________________
Phone: (___)____________ Less than 25 pgs. to be faxed: ( ) ________________

The Protected Health Information may be used or disclosed for the following purposes:
Healthcare ☐ Insurance ☐ Legal ☐ Personal ☐ Other _____________

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- **Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment and/or examination related to mental health related care, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.**

- **By signing this release, you understand that this authorization will remain in effect for**

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180 days or until revoked in writing (whichever transpires first). Dr. Talbert is authorized to use outside vendors for the purpose of copying and providing the information requested.

- **I understand that the state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Dr. Talbert cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.**

- **I understand I have the right to inspect and obtain a copy of any information disclosed.**

- **I hereby release Dr. Talbert and its employees from any and all liability that may arise from the release of information as I have directed.**

- **I understand that if I have requested duplication of records within a one year time period (of the same or similar records), I may be charged a fee of up to $1.00 per page for every page copied. This fee may be waived for copies provided to a health care provider, insurance company or other specific organizations for treatment, billing or operations purposes.**

Signature of Patient: ____ Date: _______________
***A photo ID must be provided for proof of identity or release must be notarized.**

Empowered Representative: ____________________________ Date: ____________________
***Must provide POA or supporting documentation for personal representative or healthcare surrogate**

Relationship to patient:____

Witness: ____ Date: ______________________