Bluestone Physician Services

Authorization for Release of Health Information

Patient Information: Please use full legal name.

Last Name: ________________________ First Name: ________________________ M.I. _____ Date of Birth: _____/_____/_____

Community : ____

Release Information From:

Bluestone Physician Services
10150 Highland Manor Drive, Suite 240
Tampa, FL 33610

FAX: 877-916-7631
PHONE: 813-259-1013

*Release Information To (Required):

Clinic Name: ____

Address: ____

City: ______________________________ State: ________ Zip: ___________

Phone: _________________________ Fax: _________________________

*Information To Be Released (Required): Indicate ONLY the information that you are authorizing to be released.

☐ ALL HEALTH INFORMATION ☐ CD of Images ☐ Specific dates/years of treatment ______________________

OR Release Indicated Records only:

☐ History Form	☐ Doctor/Visit Notes	☐ Laboratory Reports	☐ Operative Reports
☐ Test Results	☐ ED/ER Records	☐ Hospital Records	☐ Discharge Summary
☐ Medication History	☐ Radiology Reports	☐ Therapy Notes	☐ Radiology Images
☐ Billing Statements	☐ Procedure Records	☐ Other Information/Instructions ______________________	

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

Chemical dependency program: ☐ Yes ☐ No Psychotherapy notes: ☐ Yes ☐ No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: ___________ to ___________. This consent will expire one year from the date it is signed unless I write in a specific expiration date here: ___________.

____ ______________________

Patient or Legal Representative Signature ***Date***

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Legal Representative Printed Name and Authority to sign for patient *(i.e. Health Care Directive, Medical POA; must include documentation)*

Fax completed forms to: **MN:** 855-306-1167 **WI**: 888-972-8297 **FL:** 877-916-7631