St. John's ExpressCare P.A.

P.O. Box 695
Ponte Vedra Beach, FL 32004
904-280-1300; 904-280-1220 FAX
www.gerardjbuddmd.com

MEDICAL RECORDS RELEASE FORM

I hereby authorize St. John's ExpressCare, PA to disclose the information described below.

Patient Information	Today's Date: _____ Name: _____ Date of Birth: _____ Address: _____ _____ Telephone Number: _____ Email Address: _____
Disclose the information to this person (describe to the right), via: □ **US Mail, or** □ **FAX or** □ **Email (by signing below you acknowledge that the email will not be encrypted or secured in any way)** *(check one of the above)*	Name_____ Address_____ _____ Email address: _____ FAX: _____
Purpose for Request	□ At Request of the Patient
Requested Information	□ Medical Record □ Alcohol/Drug Treatment □ HIV-Related Information □Other: _____

EXPIRATION DATE: This authorization will expire **thirty (30) days** from the date listed at the top of this form unless a different expiration date or expiration event is written here: _____.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy. Written notice should be directed to Gerard J. Budd, MD.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. However, payment in advance of $1 per page for the first 25 pages and 25 cents thereafter is required, as allowed by Florida law. It may take up to 30 days to process your request.

Signature: _____ □ Patient □ Personal Representative

Printed name: _____