AUTHORIZATION TO OBTAIN PATIENT MEDICAL INFORMATION

I, _____ (Patient) date of birth ____/____/____, hereby request and authorize Devoted Medical Group, PLLC (DMG)

To obtain my PHI (Protected Health Information) specified:

____ All general medical records, OR

____ Limited records (specify by type of record or by date of service):

____ Including medication history from SureScripts (if applicable)

____ Including HIV/AIDS records (if applicable)

____ Including Psychiatric/Psychological Records (if applicable)

For the purpose of (check all applicable purposes):

____ Continuing to receive medical care;

____ Information for the insurance company;

____ Information for attorney;

____ Personal use, by and at the request of the patient or their legal representative; and/or

____ Other (specify):

These records to be provided to:
Devoted Medical Group, PLLC
2801 SW 149 Ave Suite 100
Miramar Fl, 33027
Phone: 1-888-973-6516
Fax: 1- 888-973-8821

Authorized By:

_____
Signature of patient or legal representative*

_____
Date signed:

*If you are signing as the patient's representative, please print your name and describe why you have the legal authority to represent the patient (for example: spouse, child, durable power of attorney for healthcare, etc.)

*Note: If your authority to act as the patient's representative comes from a document (for example: a durable power of attorney for healthcare, appointment of healthcare surrogate, appropriate estate documents or a custody decree), a copy of the document must accompany this authorization.

This authorization will expire automatically 1 year (365 days) after the date signed. You may revoke this authorization at any time by notifying DMG in writing to the Medical Records Department at the address above of your intent to revoke this authorization. The written revocation will not affect any information already disclosed to DMG prior to revocation.