



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): 321-722-5960
775 Malabar Road, Suite 105, Malabar, FL 32950 (Tel): 321-722-8435 (Fax): 321-722-8486
17 Silver Palm Avenue, Melbourne, FL 32901 (Tel): 321-733-2021 (Fax): 321-727-0884
220 Barton Blvd, Rockledge, FL 32955 (Tel): 321-639-5177 (Fax): 321-639-4927
1537 N Singleton Ave, Titusville, FL 32796 (Tel): 321-268-0267 (Fax): 321-268-3357
2120 Sarno Road, Melbourne, FL, 32935 (Tel): 321-241-6800 (Fax): 321-241-6888
7227 N. Highway 1, Cocoa, FL, 32927 (Tel): 321-877-2740 (Fax): 321-877-2793
BHA Mobile Clinic (Tel): 321-914-5864 (Tel): 321-914-5033
2120 Sarno Road, Melbourne, FL, 32935 Ste 2 (Women's Health) (Tel): 321-425-4807 (Fax): 321-241-6891
1361 Florida Ave NE Palm Bay, FL, 32905 (Tel): 321-241-6800 (Fax): 321-639-4927

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. _____ Date
Signature of Client of Legal Representative

_____ Date
Legal Representative's Relationship to Client

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