Cleveland Health Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO CLEVELAND HEALTH CENTER

1. Patient Information

Name *(First, Middle, Last)*			Cleveland Health Center Medical Record # if known:
Current Address	City	State	Zip
Last 4 Digits of Social Security #	Email	Phone Number ( )	Date of Birth / /

2. Release Information From

Facility/Provider:			
Address	City/State	Zip	Phone Number ( )

3. Release Information To: CLEVELAND HEALTH CENTER

Name of Recipient: Facility and/or Mail Code: Cleveland Health Center

Address	City/State	Zip	Phone Number	Fax Number
5463 Spencer Court	Wildwood, Florida	34785	(352) 353-0092	(352) 353-0416

Select one: ☐ Paper ☐ Secure electronic delivery (If secure delivery, provide email):

Purpose of Disclosure: ☐ **Continuity of Care** ☐ **Other (please indicate)** _____
(Purpose for disclosure must be completed prior to processing)

Dates of service to release (FROM) _____ **(TO):** _____

☐ Office Visits	☐ History & Physical	☐ _____
☐ Emergency Department Reports	☐ Other _____	☐ _____
☐ Discharge Summary	☐ _____	☐ _____
☐ Operative Reports	☐ _____	☐ _____

I, the undersigned, authorize the above named sending Facility/Provider as described in Section 2 to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to above named Facility/Provider as described in Section 2. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges.
If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ / _____ ____/____/_____

Signature of Patient/Patient's Personal Representative *Printed Name* *Date Signed*

_____

Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*

Submit completed request to the Cleveland Health Center Facility/Mailcode identified in Section 3 above.

NOTICE: If you send health information to Cleveland Health Center via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the internet.

Revision: 01/2026