Release of Medical Records

Patients Name: ______________________________ Date of Birth: ______________

Identity of Third Party or Authorized Representative: ______________________________

Street Address: ______________________________ Suite/Floor: __________

City: ______________ State: ________ Zip: ______________ Phone: ________________

Per Florida Statues, we are authorized to charge a $1.00 per page for copies of medical records.
Check the box next to each type of information to be disclosed (include dates where indicated):

- ☐ Consultation Report (specify dates) ______________
- ☐ Entire Record
- ☐ Radiology Record (specify dates) ______________
- ☐ Laboratory Results
- ☐ Other, specify ____________________________

Authorization for the Use and Disclosure of Protected Health Information: Federal law states that we cannot share an individual's health information without the individual's permission, except in certain situations. By signing this form, you are giving us permission to share the information you indicate below. If you decide later that you do not want us to share this information any more, you can revoke this authorization at any time in writing. This form must be completed and signed by the patient or by an individual who has the authority to act on the patients' behalf (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

______________________________ ______________________________
Signature of Patient or Legal Representative Signature of Witness

______________________________ ______________________________
If signed by Legal Representative, Relationship to Patient Date