1905 Clint Moore Road, Ste. 105, Boca Raton, FL 33496

PH: 561-241-4758 **FAX:** 561-998-4246

Medical Records Release Form

Requesting records from: _____

Fax: _____ **Phone:** _____

By signing this form, I authorize the release of confidential health information about me, including a copy of my medical records or a summary/narrative of my protected health information, to the physician, person, facility, or entity listed below.

Patient Name: _____

DOB: _____

I authorize the release of my protected health information to the following physician, person, facility, entity, and/or those directly associated in my medical care:

Name: _____

Delivery Method (check one):
☐ EMAIL ☐ MAIL ☐ FAX

THIS INFORMATION YOU MAY RELEASE SUBJECT TO THIS SIGNED RELEASE FORM IS AS FOLLOWS:

☐ Complete Records ☐ Care Plan ☐ Pathology Reports ☐ Hospital Reports ☐ H&P ☐ Lab Reports ☐ Medication Record ☐ Progress Notes ☐ Radiology Reports ☐ Operative Reports ☐ Other (please specify): _____

Patient Signature:
_____

Date: _____