

## MEDICAL RECORDS RELEASE FORM

**RELEASE FROM:**

\_\_\_\_\_  
 (First, Middle, Last Name)

\_\_\_\_\_  
 (Mailing Address)

\_\_\_\_\_  
 (City, State, Zip)

\_\_\_\_\_  
 (Phone number)

**FORWARD TO:**

\_\_\_\_\_  
 (First, Middle, Last Name)

\_\_\_\_\_  
 (Mailing Address)

\_\_\_\_\_  
 (City, State, Zip)

\_\_\_\_\_  
 (Phone number)

I request a copy or summary of the following medical records:

- Complete Medical Record
- Biopsy Report(s)
- Lab Report(s)
- Consultation Reports
- Surgical Procedures
- Other \_\_\_\_\_

Please check one:

- For dates of service from \_\_\_\_\_ to \_\_\_\_\_
- For all dates of service

Please check one:

- Fax \_\_\_\_\_ (enter fax number)
  - Mail :     Paper Chart     CD     USB fob    *Select option (send to FORWARD TO address)*
  - Pick up     Paper Chart     CD     USB fob    *Select option*
- Sorry, we cannot send Medical Records by email.*

Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

By signing this release, I understand that there may be a reasonable medical records copying fee as permissible by Florida State Law. By law, we are only permitted to release you medical records to you (the patient). By listing the individual above (FORWARD TO), you have given us permission to release your medical records to this person. We may require a photo ID to be sent by fax or email to us along with the form to match signatures. We cannot disclose any of your private health information to anyone who is not listed on this form.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Date of birth