# RECORDS RELEASE REQUEST

(TO ANOTHER FACILITY/PROVIDER)

TO: ROBERT E. FORD, MD, PA
2828 S. TAMIAMI TRAIL
SARASOTA, FL 34239
(941) 925-9355 FAX: (941) 925-9359

DATE_____

PLEASE RELEASE MY: _____COMPLETE (ANY AND ALL) MEDICAL RECORDS
_____MEDICAL REPORTS: _____
_____X-RAYS: _____
_____DIAGNOSTIC IMAGING REPORTS: _____
_____LAB RESULTS: _____
_____ONLY SPECIFIC RECORDS FOR THE BELOW CONDITION(S) / TREATMENT(S) / DATE(S):
_____
_____
_____HIV / AIDS STATUS: _____
_____ALCOHOL / DRUG STATUS: _____
_____PSYCHOLOGICAL / MENTAL INFORMATION: _____
_____OTHER: _____

_____PLEASE FORWARD RECORDS TO:
_____
_____
_____

_____I TAKE RESPONSIBILITY FOR RETURNING MY X-RAYS TO ROBERT E. FORD, MD, PA WITHIN THE NEXT 30 DAYS. I AM TRANSPORTING THEM FOR CONSULTATION OR FURTHER EXAMINATION REGARDING MY CONDITION TO:
_____
_____
_____

*I hereby authorize Robert E. Ford, MD, PA to release the records and information as indicated above. Such release of records or information shall in no way be interpreted as a breach of physician/patient confidentiality.*

PATIENT NAME (PRINT): _____
ADDRESS: _____
_____
PHONE NUMBER: (_____)_____
DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____

PATIENT SIGNATURE: _____

GUARDIAN SIGNATURE: _____

WITNESS: _____