

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: _____