RECORDS RELEASE REQUEST

(FROM ANOTHER FACILITY / PROVIDER)

DATE: _____

TO: _____
_____
_____
_____

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:

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

I hereby authorize _____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: _____