AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

Patient Name _____

Address _____

_____

Birth Date _____

I hereby request and authorize

_____

_____

_____ (Releasor)

to release to:

_____

_____

_____ (Releasee)

A summary of my medical record(s) for the period

ambulatory care _____ date inpatient care _____ date

emergency care _____ date other _____ date

If copy of complete record is required, check reason of need.

☐ Continue Medical Care ☐ Transfer of Records to New Provider

☐ Other _____

This consent for disclosure will be honored for 6 months from the date of signature; it expires immediately upon completion of this specific action. I understand that I may revoke it at any time except to the extent that action has been taken in reliance on my consent. Further disclosure to other parties by the release is not permitted without the written consent of the patient.

I have read and fully understand the above information and freely give my consent.

_____ Signature of Patient or Representative

_____ Relationship to Patient

PALM BEACH SPORTSMEDICINE AND ORTHOPAEDIC CENTER, P.A.

COMMENTS: