



RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize
(patient name)

(physician's name)

(address)

to release copies of medical records and other information concerning my diagnosis and treatment or related conditions. Review of records is also authorized.

The following information may be released or reviewed:

- | | |
|--|--|
| <input type="checkbox"/> Case Summary | <input type="checkbox"/> Lab Work |
| <input type="checkbox"/> Doctors Orders and Progress Notes | <input type="checkbox"/> X-ray Reports & Other Testing |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Chart problem list |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Other _____ | |

Purpose for Disclosure: _____

The above information is to be released to:

Dr Marja Sprock
1009 Harvin Way Ste. 110
Rockledge, Florida 32955

Phone (321) 806-3929
Fax (877) 362-5010

REDISCLASURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case this consent will expire on _____.

Patient's Name

Signature of Patient

SS #

Birth Date MM/DD/YYYY

Name of Personal Representative

Signature of Personal Representative

Today's Date MM/DD/YYYY

This information is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality may be protected by Federal Law

Form 20111117-1520