General Release of Medical Information and Authorization for use or Disclosure of Protected Health Information

Patient Information:

Name: _____

Date of Birth: _____ Patient SS# (last 4 digits): _XXX-XX-_____

I authorize the records of:

Provider/Entity: _____

Providers Address: _____

Phone #: _____ Fax # _____

To Disclose/release the following information *(check all that apply):

- ◯ All Records
- ◯ Lab reports
- ◯ Pathology reports
- ◯ Office/Progress Notes
- ◯ Billing records
- ◯ Radiology reports & other testing
- ◯ Operative reports
- ◯ Other: _____

Please send records listed above to the physician indicated below:

◯ Name: Marja J. Sprock, M.D.

Address: 101 Eyster Blvd
Rockledge, FL 32955

Phone: 321-806-3929

Fax: 855-657-9988

◯ Name: _____

Address: _____
_____

Phone: _____

Fax: _____

This authorization shall not be valid greater than one year from the date of signature, unless otherwise specified. Re-disclosure is prohibited without specific consent of the person to whom it pertains. I hereby authorize the release of my protected health information as specified above.

Patient or Legal Representative Signature: _____Date: _____