



Authorization to Release Medical Records

Patient Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient:

<u>Information needed for:</u>	<u>Information to be released:</u>
<input type="checkbox"/> Continuing medical care	<input type="checkbox"/> Last progress note
<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Laboratory results
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Imaging Studies
	<input type="checkbox"/> Pathology Report
	<input type="checkbox"/> Procedure Report

The above information may be released:

FROM Whom: Physician Name: _____

Practice Name: _____

Phone/Fax: _____

TO Whom: Jacksonville Nephrology
13241 Bartram Park Blvd., Suite 305
Jacksonville, FL 32258
P (904) 260-9898 FAX (904) 260-9891

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____

Signature: _____

 Printed Name of Patient or Legally Authorized Representative

 Relationship to Patient