PATIENT REQUEST FOR RELEASE OF MEDICAL INFORMATION

SECTION I: PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #
Phone #	

SECTION II: REQUEST FOR SPECIFIC ITEMS TO BE RELEASED

I request North Florida Perinatal Associates to release the medical information identified below relating to my treatment during these dates: from _____ to _____

__ Cardiovascular Reports __ Emergency Room __ Pathology Report __ Consultation Report
__ History & Physical __ Progress Note __ Discharge Summary __Laboratory Results
__ X-Ray Reports __ EKG Report __ Operative Report __ Complete Medical Record (will not be faxed)
__ Photographs, videotapes or other digital images __ Records of Prescription Medications

__ Other (describe):

SECTION III: DELIVERY METHOD

❑ Hold record for pick-up, I personally will claim the record	❑ Fax to this number: *(NOTE: Complete medical record will not be faxed)*
❑ Hold for pick-up by my authorized representative: Name: _____ (NOTE: Your authorized representative will be asked to produce proof of positive identification)	❑ Mail to this address:

SECTION IV: DUPLICATING FEES

I understand:
(1) There is no charge associated with having my records sent directly to another physician or provider to facilitate the continuity or transfer of my care.

(2) This request may take up to ten days to satisfy. _____ (initial)

SECTION V: RELEASE

I hereby release North Florida Perinatal Associates and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____
Signature of Patient or Legal Guardian Date