Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: Summit Medical Group of West Florida

Address: 11125 Park Boulevard, Suite104-133 Phone: (727) 250-0628

City: State: Zip Code: Seminole, FL 33772 Fax: (727) 491-7767

The purpose/reason for this release of information is as follows:

Medical care

Signature:

_____ _____

Patient Name | Signature of Patient or Personal Representative

_____ _____

Patient Date of Birth or Social Security Number | Printed Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority