MEDICAL SPECIALISTS OF THE PALM BEACHES, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

PATIENT NAME: ____________________________________ **DATE OF BIRTH:** ___________________________

PHONE NUMBER: _____________________________**ADDRESS:** _______________________________________

CITY/STATE/ZIP: ____

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

☐ **2 years prior from last date seen**	☐ **History & Physical**	☐ **Progress Notes**
☐ **Care Plan**	☐ **Lab Records**	☐ **Radiology Reports**
☐ **Pathology Records**	☐ **Treatment Records**	☐ **Medication Records**
☐ **HIV Records (___________please initial)**	☐ **Psychological Records (____________please initial)**	

☐ **Other Records (please specify)** ____

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PLEASE NOTE: Copy Fee may be charged for Medical Records

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

Name: ____

Address: ____

City/State/Zip: ____

The purpose of disclosure is as follows:

☐ Change of Insurance or Physician
☐ Continuation of Care
☐ Referral
☐ Other: ____

Patient Name: ____ **(Print)**

Signature of Patient or Personal Representative: ____

Date of Birth: ____ **Date:** ___________________________

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