

MEDICAL RECORDS RELEASE FORM

Charge for medical records is \$0.25 per page plus postage.

Fee is waived if records are **faxed** to your provider for continuation of care.

All records are kept in strict confidence and are not released without written patient consent.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____

ZIP CODE: _____ DATE OF BIRTH: _____/

/ _____ S.S. #: _____ - _____ - _____

I HEREBY AUTHORIZE DR. SOSA/DR. BRENNAN/MICHELLE BARNAS, ARNP AND/OR STAFF TO:

RELEASE ANY AND ALL MEDICAL RECORDS TO MYSELF (PATIENT)

RELEASE ANY AND ALL MEDICAL RECORDS AS DEEMED NECESSARY FOR MY TREATMENT TO THE FOLLOWING PHYSICIAN'S OFFICE (*CONTINUING CARE*):

OBTAIN ANY AND ALL MEDICAL RECORDS AS DEEMED NECESSARY FOR MY TREATMENT FROM THE FOLLOWING PHYSICIAN'S OFFICE (*CONTINUING CARE*):

PHYSICIAN NAME: _____ NAME OF MEDICAL OFFICE _____

PHONE #: _____ FAX #: _____

Dear Doctor: In order for us to fully evaluate this patient's health and make informed decisions, please send all relevant medical records in your file including x-ray films and reports. Please send/fax records to our office at your earliest convenience to:

1750 Tree Blvd. Ste 1
St. Augustine, FL. 32084
Fax #: 904-824-4009

Thank you for expediting this request.

Additional Comments: _____

REQUIRED SIGNATURE

PATIENT'S SIGNATURE (PARENT IF PATIENT IS A MINOR): _____

DATE: _____

SIGNATURE OF WITNESS: _____

DATE FAXED/SENT: _____ INITIAL: _____