North Florida Center for Otolaryngology
head & neck surgery
facial plastic surgery, pa

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FOR DERMATOLOGY

FACIAL rejuvenation CENTRE
PLASTIC SURGERY & MEDICAL SPA
NORTH FLORIDA CENTER FOR FACIAL PLASTIC SURGERY

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. 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: _____