

130 9th Street N, Suite 120

Naples FL 34012

(239) 649-0550 ▪ fax (239) 649-1785

**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS**

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the release of any and all of my medical records (including any and all HIV/AIDS records, alcohol and/or substance abuse records, and psychiatric and/or psychotherapeutic records.)

**Information to be released to:**

 **James M. Scanlon, M.D.**

 **Russell W. Becker, D.O.**

 **Naples Vascular Specialists**

 **130 9th Street N, Suite 120**

 **Naples FL 34102**

 **Fax (239) 649-1785**

**Purpose of disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I request that copies of my medical record be made and mailed or delivered in a timely manner to the above address.

I do hereby agree to hold Naples Vascular Specialists, its agents and staff members free and harmless from any actions by it or them for alleged invasion of privacy, liable or slander, or defamation, arising in connection with the disclosures of such information.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**