MEDICAL RECORDS RELEASE FORM

We, the office of Dr. Andres Patron want to make your transition as smooth as possible. It is important as your primary care physician (PCP), to obtain a copy of your past medical record(S). Therefore, if you would complete the form below so we may submit it as necessary to any and all of your previous attending physicians and or necessary hospital(s) in order to obtain vital medical history and information.

I HEREBY AUTHORIZE AND REQUEST THAT YOU SEND A COPY OF MY COMPLETE MEDICAL RECORD TO:

PCP: Andres Patron, D.O. **PHONE** (954) 885-5555
ADDRESS: 10796 PINES BLVD SUITE 205 PEMBROKE PINES, F L 33026 **FAX** (954) 885-5333

PATIENT'S NAME: ______________________ **Relationship to Patient** ______________

SSN: ______________________ **DOB:** ______________________

ADDRESS: ____

I hereby authorize the release of all medical documentation and other information including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse and or any other covered entity under HIPAA Accountability Act of 1996. *Information to be obtained and or forwarded as follows:*

History & Physical	Laboratories	Eye Exam
Progress Note	XRay/Scans	Pap/Cervical Scrn
Consultation/Counseling	EKG/EEG	Mammo
Narrative Summary	Treatment Plan	ColoKit/Colonoscopy

This may also authorize PatronMedical to release /obtain general health Information as well as
1). psychiatric/psychological treatment, 2). HIV/AIDs diagnosis as well as 3). Alcohol and 4). Drug Abuse information, from my medical record, *in accordance with Florida Statutes and Federal regulations.* In addition but not limited to any test, counseling and results of treatment(s), thereof are also authorized. I understand that my records have a privilege and confidential status, and I am in approval and acceptance of such order/request in an effort to establish, provide and set forth an accurate medical patient history and physical Upon Presentation of this authorization or photocopy of you are authorized to release a copy of the records to any person who is my personal representative. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law. The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all the requirements of HIPAA; 45cfr section 16.

PATIENT OR LEGAL GUARDIAN SIGNATURE: ______________________________________

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending a written and certified notice to my medical provider(s) and revoking a health care agency under law.

Witness **to Patient of legal Guardian Signature.:** ______________________________________