AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Kimberly A. Dean, DO Mark C. Stine, D.O. Jason H. Howard, D.O. Nicholas Z. Okeson, D.O.

13787 Belcher Road South, Ste 100
Largo, FL 33771
Phone: (727) 535-9899 Fax: (727) 535-2818

NAME OF PATIENT (print) _____ DATE OF REQUEST ____/____/_____

PATIENT MAY ALSO BE KNOWN AS: _____

DATE OF BIRTH ____/____/____ SOCIAL SECURITY (LAST 4 ONLY) XXX-XX-_____

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
Name: _____ Address: _____ _____ _____ Phone: (_____) _____ Fax: (_____) _____ **DO NOT FAX IF OVER 20 PAGES**	Name: _____ Address: _____ _____ _____ Phone: (_____) _____ Fax: (_____) _____ **DO NOT FAX IF OVER 20 PAGES**

PURPOSE OF RELEASE: ___Treatment/Continued Care ___Legal Purposes ___Personal
___Other (explain) _____

INFORMATION TO BE RELEASED (Required)

_____All Routine Records (Notes, History & Physical, Labs, Radiology, Diagnostic Testing)

_____Other: (explain) _____

_____Specific Service Dates From: _____ To _____

* I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
* This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it.
* Revocation must be made in writing to the provider/facility releasing the information.
* The provider/facility will not condition treatment on whether I sign the authorization.
* **I may be charged for copies in accordance with state law.**
* Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.
* The authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

_____ _____
Patient or Guardian Signature Date Signed

_____
Printed Name of Person Signing