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 to any and all of your previous attending physicians in order to attain your medical history and vital 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

MEDICAL RECORDS

PATIENT'S NAME: _____Date_____

SSN: _____ DOB: _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

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 or any other covered entity under HIPAA Accountability Act of 1996. All of the medical history and physical & mental condition both Prior to and Subsequent to the date of this authorization, regardless of lapsed time. The person(s) named abouve is/are herby designated as my "personal representative(s)" and Primary Care Physician as the term is used within HIPAA.

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.: _____