South Florida Breast Specialists

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Medical Records Request

Authorization for Use, Disclosure, and Release of Health Information

Date _____

Patient _____ DOB_____

The above named patient requests and authorizes the release of their medical records

OBTAIN or RELEASE (circle one) MY HEALTH INFORMATION TO or FROM (circle one)

_____

(Full Name of Physician or Facility)

_____

(Phone) (Fax)

Please Include:

____ Office Notes

____ Lab Results

____ Diagnostic Results

____ Pathology/OP Reports

____ All Records

_____ _____

Patient Signature (or Legal Representative) (Date)