East County Internal Medicine

REQUEST FOR RELEASE OF RECORDS

I, ____, request a copy of my complete medical record

from the office of:

____

Name of Office

____

Address of Office

To be sent to East County Internal Medicine:
6050-B State Road 70 East, Bradenton, FL 34203
P: 941-727-7771 F: 941-251-0488

______ I give permission to Fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for East County Internal Medicine to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

____ ________________

Print Patient Name Date

____

Patient Date of Birth

____ ______________

Signature Patient, Parent, or Legal Guardian/Representative Date