Jacksonville CLINIC

MEDICAL RECORDS REQUEST FORM

TO: _____ **PATIENT:** _____

_____ **S.S. #:** _____

_____ **D.O.B:** _____

The release of any information considered confidential under Florida Law, such as that regarding psychiatric, drug or alcohol abuse, HIV/AIDS testing, counseling, or treatment, or other sensitive materials which may or may not be in my medical records is:

_____ **AUTHORIZED** **OR** _____ **UNAUTHORIZED**

This written request for release of medical records is valid for 6 months from the date of my signature unless revoked in writing by me or my authorized agent.

I agree to hold both the sending and receiving parties to this request harmless from any and all costs, liability and damages of any nature resulting or indirectly from the release of my medical records.

___LAST OFFICE VISIT NOTES

___HISTORY AND PHYSICAL

___ECHO DOPPLER

___STRESS TEST (NUCLEAR/TREADMILL)

___MAMMOGRAM

___PET SCAN

___LABS

___COLONOSCOPY

___TEE

___ALL AVAILABLE RECORDS

___OTHER _____

_____

___PAP SMEAR_____

___**STAT PATIENT IN OFFICE**

_____ _____ _____

PATIENT SIGNATURE **DATE** **WITNESS**