Boca Raton Family and Family and Pediatric Center
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561-477-2862 · 561-477-2864 (fax)

MEDICAL RECORD REQUEST

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name_____ DOB: ___/___ /___
Address: _____
Phone Number:_____

PLEASE RELEASE MY MEDICAL RECORDS FROM:

PROVIDER OR HOSPITAL: _____
ADDRESS: _____
_____
PHONE: _____
FAX: _____

TYPE OF RECORDS TO BE RELEASED:

Progress notes, operative notes, laboratory test results, diagnostic tests, immunization records, and x-rays.

_____ Records of care from _____ to _____.

_____ Records of care concerning the following condition(s)

_____

_____ Other. Specify: _____

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.
Do not release □ HIV □ Mental Health (Psychiatric) □ Drug & Alchol

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ Date: _____
Patient's Signature

PLEASE FAX TO: 561-477-2864