Medical Records Release Form

Attention:_____
_____
_____

Patient Name:_____**Date of Birth**:_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility/entity listed below.

Starr Internal Medicine and Associates
Dr. Daniel Starr, MD
8247 Devereux Drive, Suite 102, Viera, FL 32940
Ph: 321-610-4960 Fax: 321-610-4362

The information you may release subject to this signed release form is as follows:

☐ Complete records	☐ History and Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Records	☐ Other (Please specify):

The purpose/reason for this release of information is as follows: **_Establish Care/continuity of Care_____**

_____

_____
Signature of Patient or Representative

_____
Description of Personal Representative's Authority

_____
Date