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Authorization For Disclosure of Medical Record Information

Patient Name: (First, Middle, Last)					
Address:				City	State
Zip	Date of Birth:				
Phone #:	Email Address:				

I hereby authorize: _____

To: Release my medical record information to Surgical Specialists of Southwest Florida P.A.
 13731 Metropolis Avenue
 Fort Myers, FL 33912
 Secure Fax# **239-936-5611**
 Email address to send secure file: appointments@surgspecswfl.com

Please check all that apply:

<input type="checkbox"/>	I am requesting the following medical records.						
<input type="checkbox"/>	Visit Summary	<input type="checkbox"/>	Lab Reports	<input type="checkbox"/>	Medications List	<input type="checkbox"/>	Radiology Reports
<input type="checkbox"/>	History & Physical	<input type="checkbox"/>	Other: List				

Records will be Mailed Emailed Faxed

Signed: Patient		Date:	
Signed: Patient Representative		Date:	
ID Provided:			
Request Taken By Phone (Verification)			