Art of Medicine, P.A.

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MEDICAL RECORDS REQUEST AND RELEASE

REQUEST FOR RECORDS

Records to be received from:
Name _____
Address _____
_____

Purpose to transfer of records _____

RELEASE OF RECORDS

Records to be sent to:
Name _____
Address _____
_____

Purpose to transfer of records _____

ALL PATIENT INFORMATION IS CONFIDENTIAL AND PRIVILEDGED
The confidentiality of all patient records is protected by Federal Law.
The recipient of patient information is prohibited from making any further disclosure.

1. I authorize Art of Medicine, P.A. to release or obtain all medical information including, but not limited to information relating to medical history & conditions, psychiatric history, sexual history, child abuse or neglect, alcohol and drug abuse, HIV status, AIDS or AIDS related conditions.
2. I agree to hold Art of Medicine P.A. harmless form any and all costs, liability and damages of any nature whatsoever including reasonable attorney's fees, resulting directly or indirectly from the release of my medical records pursuant to this request.

I acknowledge that I have read this authorization and fully understand its contents.

_____ DOB:_____
Printed Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date of Request