MEDICAL RECORDS REQUEST

Date: ___/___/___
Patient Name: _____ Date Of Birth: ___/___/___

Medical Records: __ Requesting From __ Releasing To

Patient/Doctor _____

Address: _____
City: _____ State: _____+ Zip: _____

I request a copy of the following medical records *for all dates and services:

Complete Medical Records
Imaging Report(s)
Laboratory Report(s)
Other _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are herby authorizing disclosure of this information.

I release Foot and Ankle Institute Of Central Florida from any laws related to the disclosure of confidential or privileged information. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Thank you for your consideration and prompt attention regarding my medical records.

_____ ____/____/_____
Signature Of Patient/Guardian/Healthcare Power of Attorney **Date**

_____ ____/____/_____
Signature of Witness **Date**

Foot And Ankle Institute Of Central Florida Fax: 863.644.7272