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502 S. Macdill Avenue
Tampa, Fl. 33609-3039
(Ph) 813-877-5111 (Fax) 813-877-1222

RECORDS RELEASE AUHTHORITY

AUTHORIZATION TO SEND MY RECORDS TO: MEDI CLINICS PRIMARY CARE

Patient Name_____ Date of Birth:_____
(Patient's name or Guardian)

SSN#_____

To Records Custodian:

I hereby authorize_____
(Name and address of Hospital/Physician Facility)

_____

to release information specified below from my medical records. This medical information should be released to the physician listed below.

Medi Clinics Primary Care
502 S. Macdill Ave.
Tampa, Fl. 33609

Please send a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me for the continuity of care purposes.

Check off items being released:

☐ All Records
☐ Consultation Reports
☐ Immunization
☐ Laboratory
☐ Radiology
☐ Most Recent Physical
☐ Other_____

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Medi Clinics Primary Care, LLC and its staff from any restriction or privileges imposed by law in connection with the disclosure or release of any professional record, observation or communication. I do understand that the information that is being released may be subject to re-disclosure by the released may be subject to re- disclosure by the recipient and may no longer be protected.

This authorization may be revoked in writing at anytime, except to the extent that Medi Clinics Primary Care, LLC has already taken action in reliance on it. Letter to revoke this authorization should be addressed to Medi Clinics Primary Care, LLC 502 S. Macdill Ave. Tampa Fl. 33609. If not previously revoked in writing, this authorization will not have any expiration date.

_____ _____ _____
Signature of Patient or Authorized Representative Relationship to Patient Date