Medical Records Release

Sunshine Physicians keeps a blank records release on file for you in case you require us to receive medical records on your behalf in the future.

Please fill out the "Patient Information" section only and sign the bottom. Do NOT fill out the grey shaded area.

If you have a specific doctor/facility you would like to request records from, we can print out this pre-filled form for your usage.

Thank you,

Sunshine Physicians

Authorization to Release Medical Records

Date: _____

PATIENT INFORMATION			
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**CELL PHONE**
PATIENT DATE OF BIRTH	**PATIENT SSN**	**SEX** ❑ Male ❑ Female	

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:				
ORGANIZATION		**STREET ADDRESS**		
CITY	**STATE**	**ZIP**	**PHONE**	**FAX**

INFORMATION TO BE RELEASED TO:				
ORGANIZATION Sunshine Physicians		**STREET ADDRESS** 1730 Dunlawton Avenue, Suite 1		
CITY Port Orange	**STATE** Florida	**ZIP** 32127	**PHONE** (386) 320-3299	**FAX** (877) 991-1880

INFORMATION TO BE REALEASED:

Dates of Service for Records Requested: Beginning ( ) Through ( )

❑ **Entire Chart** ❑ **Labs** ❑ **Radiology** ❑ **Other Testing** ❑ **Clinic Notes** ❑ **Vaccination Record**

❑ **Other (Specify)**

PURPOSE OF RELEASE:

❑ **Continuing of Care** ❑ **Transferring to another provider** ❑ **Copies for own use** ❑ **Legal purposes**

❑ **Other (Specify)**

AUTHORIZATION FOR GENERAL RELEASE INFORMATION:

This Authorization:

❑ Is voluntary and is not required for obtaining treatment of payment, unless the sole purpose of this Authorization is to determine payment of a claim for benefits.

❑ Will expire in 12 months from the date signed below unless another date or event is entered here ( )

(Note: If the disclosure is to an employer or financial institution, this authorization will expire in 90 days from the date you signed)

❑ May be revoked at any time by writing to Sunshine Physicians, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected.

The following sensitive records require specific patient authorization. Please Check the applicable box below to request the following records:

❑ Sexually Transmitted Diseases ❑ AIDS/HIV ❑ Alcohol/Drug Abuse Treatment ❑ Mental Health Treatment

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.

Release: I release Sunshine Physicians, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:	
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**