

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION:

This authorization is for the release of medical information.

PATIENT'S NAME: _____ BIRTH DATE: ____/____/____

ADDRESS: _____

SOCIAL SECURITY NO: _____ DAYTIME TELEPHONE: _____

ORGANIZATION PROVIDING INFORMATION:

Name of Physician or organization releasing information

Street Address

City, State, Zip

_____/_____
Phone Fax

ORGANIZATION REQUESTING INFORMATION:

ATTN: Tami

Jacksonville Surgical Associates P.A.
Dr. Robert Cywes

8825 Perimeter Park Blvd
Suite 101
Jacksonville, Florida 32216

904-399-4004 ext. 120
Phone

904-399-3489
Fax

INFORMATION TO BE DISCLOSED

- Medical Notes/Summary Pathology History & Physicals X-rays, EKG
 Operative/Procedure Reports Recent Labs All Medical Records **Other , Please send ONE progress sheet from each year this patient was seen showing his or her highest weight and date. EX: Progress sheet from 09, 08, 07, 06,**

AUTHORIZATION & SIGNATURE

I hereby authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release **Jacksonville Surgical Associates, P.A./Jacksonville Weight Loss Center** from all liability arising from this disclosure of my health information. This release will expire in one (1) year.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ Date: _____

Patient Signature: _____ Social Security Number: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Signature of Parent, Guardian or Legal Representative: _____

Send by: **Fax** or if > than 15 pages **Please Mail**

Records needed by: _____