

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: \_\_\_\_\_

**OFFICE USE ONLY**

**ORGANIZATION PROVIDING INFORMATION:**

\_\_\_\_\_  
Name of Physician or organization releasing information

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_/\_\_\_\_\_  
Phone Fax

**ORGANIZATION REQUESTING INFORMATION:**

**ATTN: Karma**

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 11,10,09, 08,**

**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:** \_\_\_\_\_