REQUEST FOR MEDICAL RECORDS

I Authorize (Releaser of Medical Records): Florida Joint Care Institute
2165 Little Road
Trinity, FL 34655

To Release the Following Medical Records for Ongoing/Continued Medical Care and to:

Provider's Name: _____

Street Address: _____

City/State/Zip Code: _____

Phone: _____ Fax:_____

____ Please send the Entire Medical Record (all information) to the above named recipient.
____ All Therapist/ Technician records
____ Office Notes and Reports
____ Medical Records needed for continuity of care
____ Most recent one-year history
____ Most recent five-year history
____ Clinician office chart notes
_____ Transcribed Hospital Reports
_____ X-Ray films on a CD
_____ Laboratory Reports
_____ RX
_____ Diagnostic Imaging/X-Ray Reports
_____ Billing Statements
____ Other_____

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period of one (1) year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

I would like these records to be: ___ PICKED UP ___ MAILED ___ FAXED

_____ __ _____ _____
Print Patient's Name **DOB** Date:

_____ _____
Signature of Patient or Pt's Legal Representative Date: