12276 San Jose Blvd., Ste 617, Jacksonville, FL 32223
Phone (904) 262-9075 Fax (904) 262-9076
www.fountainfamilymedicine.com

REQUEST FOR RECORDS

Records to be sent **from** the following address:

Dr's First and Last Name:_____

Address:_____ City:_____

State:_____ Zip Code:_____

Phone #:_____ Fax#:_____

Reason for release of records:_____

Records to be **released to:** Fountain Family Medicine.

Please send only the **last two years of labs and imaging**, and the **last two office notes**.

Please send **paper copies only**.

As a part of the Medical Record, the following information will be released unless crossed out:

Sexual Abuse Information

Drug & Alcohol Abuse Information

Child Abuse & Neglect Information

Psychiatric Information

AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above specified information. The information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire one year from date of signature.

Patient/Guardian Signature:_____

Date:_____ Witness:_____

Print Name:_____ DOB:_____

If the patient is unable to sign due to mental or physical disability, or is a minor, authorization must be signed by the legal guardian.