REQUEST TO RELEASE MEDICAL RECORDS

TO:_____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY, STATE & ZIP

I HEREBY REQUEST THAT MY:

_____COMPLETE RECORDS
_____ X-RAYS
_____ CONSULT REPORTS
_____ LAB TESTS
_____ EKG/ECG
_____ OTHER_____

RELEASE TO:

BRADENTON EAST INTEGRATIVE MEDICINE, PA

* KAREN BRAINARD, MD_____* ROBIN JAMES, ARNP_____
*JAMES LEIBER,DO_____*MAUREEN O'REILLY,ARNP_____

6120 53RD AVENUE EAST
BRADENTON, FL. 34203
PHONE: (941) 727-1243
FAX: (941)751-9039

FOR THE PURPOSE OF CONTINUITY OF CARE

_____

PATIENT'S NAME

_____-_____-_____ DATE OF BIRTH

_____-_____-_____ SOCIAL SECURITY #

_____ SIGNATURE

_____-_____-_____ DATE

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING UNLESS OTHERWISE INDICATED. THE PATIENT MAY REVOKE THIS AUTHORIZATION AT ANYTIME UPON REGUEST. THE DISCLOSED INFORMATION MAY NO LONGER BE PROTECTED BY THE PRIVACY PRACTICES OF THIS PRACTICE.