



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Dr Bart Price, 1250 S Tamiami Trail, Suite 301, Sarasota, FL 34239. 941-365-1321/Fax 941-365-4071 upon request in person or by mail to the address specified at the time of the request.

Provider: <i>(name & address)</i> 	Patient: DOB:
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RECORDS AUTHORIZATION TO BE RELEASED:

Admission history and physical Discharge summary Mammogram Office notes Outpatient records Immunization records Other <i>(specify)</i> _____ _____ _____	Lab reports Radiological reports Consultation notes or reports Bone density report Colonoscopy with pathology
Extent or nature of records to be released: <i>(example, specific hospitalization or visit)</i> _____ _____ _____	

This information will be used for the purpose of Continuity of Care.

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the _____, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Representative Signature	Date
Name of Representative	
Relationship to Patient	