



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Dr Petra Travnicek, 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.

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

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

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	