



## 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.

|                                              |                 |
|----------------------------------------------|-----------------|
| <b>Provider:</b> <i>(name &amp; address)</i> | <b>Patient:</b> |
|                                              | <b>DOB:</b>     |

### RECORDS AUTHORIZATION TO BE RELEASED:

|                                                                                                       |                               |
|-------------------------------------------------------------------------------------------------------|-------------------------------|
| Admission history and physical                                                                        | Lab reports                   |
| Discharge summary                                                                                     | Radiological reports          |
| Mammogram                                                                                             | Consultation notes or reports |
| Office notes                                                                                          | Bone density report           |
| Outpatient records                                                                                    | Colonoscopy with pathology    |
| Immunization records                                                                                  |                               |
| Other <i>(specify)</i> _____                                                                          |                               |
| 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