CONCIERGEMEDICAL
SERVICES

BOARD CERTIFIED INTERNAL MEDICINE

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.

Provider: *(name & address)*	**Patient:** **DOB:**

RECORDS AUTHORIZATION TO BE RELEASED:

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

_____

Extent or nature of records to be released: *(example, specific hospitalization or visit)* _____

_____

_____

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