TREASURE COAST Primary Care

Medical Records Custodian Office
1980 SE Ocean Blvd. • Stuart, FL 34994 • **772-678-7043**
www.**tcprimarycare.com** | Secure Fax: **772-403-2379**

MEDICAL RECORDS RELEASE

The following patient requested that their records be released as listed below.

RE: PATIENT: _____ DOB: _____ / _____ / _____

SSN: _____ DATES NEEDED: _____ ☐ ALL

RELEASE RECORDS FROM: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

RELEASE RECORDS TO: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

Health Information to be disclosed upon the request of the person named above.

☐ **Disclose my complete health record**
(Including but not limited to diagnoses, lab tests, prognosis, treatment and billing for ALL conditions)

☐ **Disclose my health record as above BUT DO NOT INCLUDE**

☐ Mental Health ☐ Alcohol/Drug Treatment

☐ Communicable Diseases (including HIV & AIDS)

☐ Other (please specify) _____

*PLEASE MAIL IF OVER 25 PAGES

FOR THE PURPOSE OF CONTINUITY OF CARE UNLESS OTHERWISE NOTED: _____

Pursuant to Florida Law, the records may be used only for the purpose provided and to whom requested. Any information may not be disclosed to any other person without the specific written consent of the undersigned. Changes are in compliance with Florida Law. I understand I may revoke this consent at any time before the information has been released.

_____ _____
Name of the Individual Giving this Authorization (print) Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

Witness: _____ Date: _____