REQUEST FOR RELEASE OF RECORDS

I, ____, request a copy of my complete medical record from the office of:

____

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Name and Address of Practitioner

To be sent to:

Florida Oncology Tavares
2010 Nightingale Lane
Tavares, Florida 32778
Phone 352-742-3045 Fax 352-742-3169

√	Item	√	Item
	Office Visit Note		MRI films and reports
	Pathology Report		Bone scan films and reports
	Operative Report		Lab Results
	Discharge Summaries		Radiation Treatment Records
	CT scans and reports		Simulation/Port Films
Other:			

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Oncology Tavares to receive copies of any medical, psychiatric, Aids, Aids relates syndromes, HIV testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire ninety (90) days after the date below or sooner at my election.

____ ______________________

Print Patient Name Date of Birth

____ ______________________

Signature Patient, Parent or Legal Guardian/Representative Date