

201 NW 82nd Ave, Suite 104 Plantation, FL 33324

Phone: 954.472.2201 Fax: 954.472.2501

MEDICAL RECORDS AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By State Law you must be advised that:

The information you authorized for release may include information that should be considered information about communicable diseases, which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS")

Patient Name:	Date of Birth:
Social Security Number:	Treatment Date:
I hereby authorize:	
Name:Organization :	
NameOrganization .	
Address:	
Telephone:Fax	x:
to release all the following health record (s) information of the above name patient, covering the period(s) indicated for the following purpose:	
☐ Insurance Payment ☐ Transfer of Care ☐ Other	My Doctor's Use
The information to be release: Pap Smear/Biopsy Results Lab/Pathology Operative Report(s) Radiology Reports Prenatal Records Consultations History & Physical Exam Mammogram Report(s)	AIDS/HIV Test Results Bone Density Report(s) All Records Other
This information is to be release to: Dr. Robert Bass, MD 201 NW 82 nd Ave, Suite 104 Plantation, FL 33324 Phone: 954.472.2201 Fax: 954.472.2501	
I understand this consent can be revoked at any time except that disclosure made in good faith has already occurred in reliance on this consent. Without prior revocation this authorization will automatically expire one year from this date. If the copies of the records are not retrieved within 60 days they will be shredded	
I am also informed that health records will be released to the person(s) or organization(s) named above, to those persons or organizations I have other releases granted and to persons or organizations authorized by law.	
Patient Signature Date	Witness Signature Date
Person Authorized to Sign for Patient	Relationship to Patient
Date of 1 st Request	Date of 2 nd Request