AUTHORIZATION TO RELEASE/ OBTAIN MEDICAL RECORDS

Today's Date: _____ /_____/ _________

Patient Name: ____

Date of Birth: _____ /_____/ _________

Phone: ______________________________ Email: ____

Records Released From:

Name: ____

Address: ____

City: ____State: _________________Zip: ____________

Phone: ____Fax: ______________________________

Records Released To:

Name: Surgical Arts of Boca Raton

Address: 9980 N Central Park Blvd Suite 113 Boca Raton FL 33428

Phone: 561.717.3660 Fax: 561.717.3650

Email: info@surgicalartsofbocaraton.com

Information to be Release/Obtained:

- I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization.
- I understand that the PHI used, disclosed, or released pursuant to this authorization may be subject to redisclosure by the recipient of my PHI and will no longer be protected by state or federal privacy regulations.
- I authorize Surgical Arts of Boca Raton to release or obtain medical records as specified above.

SIGNATURE (Patient or Authorized Representative) ____

PRINTED NAME (Patient or Authorized Representative) _______________________________________

Date: ___________________