



Medical Records Request or Release

Release of Records: Records to be sent to the following address:

PMC
5960 Beach Blvd., Suite 3
Jacksonville, FL 32207
Ph- (904) 265-1942
Fax- (904) 265-1952

Reason for Release of Records: _____

Request for Records: Records to be received from:

Physician/Facility: _____

Address: _____

City, State, Zip: _____

Ph: _____ Fax: _____

Release from my medical records the following information for the following dates:

From: _____ To: _____

As part of the medical record, the following information will be released unless crossed out:

- SEXUAL ABUSE INFORMATION**
- DRUG & ALCOHOL ABUSE INFORMATION**
- CHILD ABUSE & NEGLECT INFORMATION**
- PSYCHIATRIC INFORMATION**
- AIDS/HIV**

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed: _____ Date: _____
Patient, Parent or Guardian

Patient Name: _____

Date of Birth: _____ SS# _____

Witness: _____ Date: _____