Medical Records Release Form

Name:

____

Address:

____

(Street) (City) (State) (Zip)

Home Phone: ______________________

Work Phone: _______________________

Birth date: _____/_____/_____

Please transfer my medical records:

From: _____________________________

____

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To: Geriatric Review
P.O. Box 111270
Naples, Fl, 34108-0122

Please send these medical records to Geriatric Review:

- ☐ All History and Physicals
- ☐ Last 3 years of progress notes
- ☐ Last 3 years of laboratory test

- [ ] Last 3 years of radiology records (including CT, MRI, Mammogram, Bone Densities)
- [ ] Last 3 EKGs
- [ ] Last 3 years of consultive reports

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment for HIV/AIDS, and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial the box below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

- [ ] Drug and/or alcohol abuse, diagnosis or treatment
- [ ] HIV/AIDS testing and/or treatment
- [ ] Psychiatric care and/or mental illness
- [ ] Confirmed STD test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

____
(Signature)

____
(Witness)

____
(Interpreter, if necessary)

____
(Date)