North Florida Medical Clinic
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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize North Florida Medical Clinic to ( ) release or ( ) obtain the following medical records.

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____

Reason for Request: Please Check One

_____ Moving ____ Transferring Doctor _____ Insurance/Work Purposes

If transferring doctors, please list reason why _____

Please: ( ) Send them to OR ( ) obtain them from the following address:

Name of Physician/Institution: _____

Address: _____

City, State, Zip: _____

Phone Number: ( )_____ Fax: ( )_____

This consent includes authorization to FAX my medical records that may contain information concerning: HIV, drug or alcohol abuse, venereal disease or psychiatric care. I further agree that North Florida Medical Clinic, it's physicians, employees or designated representatives shall not be held liable in any manner for furnishing or having obtained such information.

This authorization shall expire 90 days from date of request.

_____ _____
Patient's Signature (Parent or Guardian if Minor)

_____
Date of Request

If the patient is a minor, mentally incompetent, or deceased, the next of kin, legal guardian or executor of the estate may sign.