Suncoast Internal Medicine Consultants

13644 Walsingham Road; Largo, FL 33774-3532
727-595-2519 Fax 727-595-3872

Authorization for Release of Medical Information

TO: ____
(Previous Physician)
City and State:______________________________________
Phone____
Fax:____

Please release the following information to:
Suncoast Internal Medicine Consultants
Dr. ____________________________
13644 Walsingham Road
Largo, FL 33774-3532
727-595-2519 Fax 727-595-3872

_____Labs _____Imaging _____Last 3 Office Notes Other___________________________

The purpose of this disclosure is for continued medical care.

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I hereby authorize you to release my medical records. I understand my records may include information related to alcohol or drug abuse, communicable diseases, HIV testing and results, and psychiatric or psychological conditions.

Patient Name____
Please Print

Last Four Digits of Social Security Number____________________Date of Birth_____/_____/_____

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_____Mail _____Fax _____Pick-Up Date___________

I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by notifying **SIMC** in writing. However, the revocation will not be valid to the extent that **SIMC** has taken action in reliance on this authorization.

Patient Signature____Date_____________________

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Personal Representative's Name, Signature and Relationship If Unable to Sign