EAST HILL
MEDICAL GROUP
99B South Alcaniz Street- Pensacola, FL 32502
850-437-0035-office 850-429-0005-fax

MEDICAL RECORD RELEASE AUTHORIZATION

Name of Patient (Please Print): _____

Date of Birth: _____

Address: _____

I hereby authorize the below listed facility, provider or entity to release my medical records to East Hill Medical Group.

Name _____

Address _____

City _____ State _____ Zip _____

Fax _____

Medical Information Requested:

_____ All Records
_____ Specific Records from_____to_____
_____ Immunizations & Physical Examinations
_____ Radiology Films (X-rays, MRI, CT scan, etc.)
_____ Laboratory Tests

_____ _____

Signature of Patient/ Responsible Party **Date**

This release authorizes the disclosure of records for one year from this date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, had already done so in reliance on the consent.

_____ _____

Signature of Patient/ Responsible Party **Date**