

**Release of Medical Record Request**

Steven A. Crews, DO, PA

*Authorization for disclosure or use of protected health information*

Please complete this form in its entirety, items not checked or blanks unfilled are assumed to be non applicable or specifically no authorization for release. This release is not valid if it does not contain the patient's signature and date signed or if it has expired as described below.

Patient Name (Last, First MI)

Date of Birth (DOB)

I hereby authorize (name of provider or entity) to release my medical information for purpose of: (Choose one by circling)

Continuity of Care    Personal    Insurance    Other

**CHARGE for MEDICAL RECORD COPIES as per State Statute is \$1.00 per page for the first 25 pages and \$0.25 for subsequent pages.**

FROM	TO	FROM	TO	FROM	TO
		Steven A. Crews, DO, PA			
		Family Practice			
		8135 Centralia Court, Suite 101			
		Leesburg, FL 34788			
		Telephone	(352) 360-0654		
		SECURE FAX	(352) 360-0668		

**ATTN MEDICAL RECORDS -----PLEASE FAX RECORDS TO OFFICE SECURE FAX**

The following information is to be disclosed or used (please check)

Medical record- (last 2 years, current diagnostic and laboratory reports)\*\*\*

Medical records related to\*\*\*

Specific Condition (s) \_\_\_\_\_

Specific Date \_\_\_\_\_

Specific test \_\_\_\_\_

Other \_\_\_\_\_

**PLEASE NOTE**

**We will fax current records to other physician/providers at no charge but is limited to current year visit and current labs and diagnostics as needed for continuity of care-**

**WE DO NOT MAIL RECORDS WITHOUT PAYMENT**

**We do not forward hospital records or notes/labs/procedure reports from other providers.**

\*\*\* I understand that these records may include information relating to: Acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases (STD), treatment for drug/alcohol abuse or Behavioral Health/Psychiatric care.

**Affirmation of Release:**

By signing below I give permission to the above named provider or their representatives to release only the information I have selected on this form. I understand this release is valid up to one year from the date that I signed it and may be revoked at any time. I understand that I may refuse to sign this authorization. I further understand that the information used or disclosed pursuant to the authorization may be re-disclosed by the recipient and no longer protected by federal and state privacy laws. I also understand that I have the right to copy this authorization form, but not the records obtained by the form.

Signature Of Patient/Guardian/Legal Representative

Print NAME

Relationship to Patient (Please Circle)

Self      Parent      Other

Date Signed:

Expiration date is one year from date signed unless revoked otherwise.