FLOMED INFUSION

6274 Linton Blvd. Suite 105 | Delray Beach, FL 33484
T: 561-559-9800 F: 561-559-9801
flomedinfusion.com

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

By signing this form, I authorize you to release confidential health information about me. By releasing a copy of my medical records or a summary or narrative of my protected health information.

Patient's Name: _____

Patient's Social Security Number: _____

Patient's Date of Birth: _____

RELEASE RECORDS FROM

Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

SEND RECORDS TO:

FloMed Infusion Services LLC
6274 Linton Blvd. Suite 105
Delray Beach, FL 33484
T: 561-559-9800 F: 561-559-9801
flomedinfusion.com

USE OF INFORMATION

Electronic Health Records: I understand that FloMed Infusion Services LLC may collaborate with other health care providers to coordinate, manage and provide health care to me. I voluntarily consent to FloMed Infusion's sharing of my health information, electronically or otherwise for the purpose of treatment, payment and operations. **Request for Information from Others:** I consent to FloMed Infusion Services LLC request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal or electronic.

AUTHORIZATION

This authorization applies to all healthcare information related to your treatment plan. Records should include all relevant chart notes, test results, demographics, insurance, and the most recent medical history and annual physical.

I hereby authorize and request the prompt release of the medical records without exception.

PATIENT SIGNATURE AND DATE

Patient Signature: _____ Today's Date: _____