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**Medical Records Release Form**

**Attention**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, to the physician/facility/entity listed below.

**Starr Internal Medicine and Associates**

**Daniel Starr, MD**

**Julie Starr, APRN**

**8045 Spyglass Hill Road, Suite 105, Viera, FL 32940**

**Ph: 321-610-4960 Fax: 321-610-4362**

The information you may release subject to this signed release is as follows:

* Complete records 🞎 History and Physical 🞎 Progress Notes
* Care Plan 🞎 Lab Reports 🞎 Radiology Reports
* Pathology Reports 🞎 Treatment Record 🞎 Operative Reports
* Hospital Records 🞎 Medication Records 🞎 Other (Please Specify):

The purpose/reason for this release of information is as follows: \_\_\_\_**Establish care**/\_\_\_\_**Continuity of care**

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**Signature of Patient or Representative** **Date**

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**Description of Personal Representative’s Authority**