#

AUTHORIZATION TO REQUEST RECORDS

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Request Medical Information from:

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Send Medical Information to:

Tammy L. Birbeck DO
Gulf Women's Center for Health & Surgery
2061 Englewood Rd Suite 4
Englewood, FL 34223-1747
941-681-2042 Phone
941-208-5982 Fax

- ☐ Release the complete medical record in your possession concerning my illness and/or treatment unless otherwise requested.
- ☐ All Records during the period from _____ to _____
- ☐ Other: _____

Reason for your request:

- ☐ Moving out of the area
- ☐ Primary physician needs records
- ☐ Copy for northern physician
- ☐ Other (please explain): _____

By signing below, you authorize the release of the information requested above. I understand that information such as Mental Health Records, communicable diseases, alcohol/drug abuse treatments etc may be released unless specifically stated not to be released.

_____ _____

Patient or Legal Representative Date