Florida Keys Concierge Medicine
305-849-0463

**RELEASE OF PATIENT INFORMATION**

TO:

_____

Name of Healthcare Provider Requesting Information From

RE:
Patient Name:_____

Date of Birth: _____ Social Security Number: _____

_____

Street Address

_____

City, State and Zip Code

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to:

**Dr. Gregory Keifer**
**Fax: 305-203-4308**
**Phone: 305-849-0463**

This disclosure should include:

- Office notes; inpatient, outpatient and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.
- Laboratory records and specimens; radiology records and films.
- Prescription records and drug information related to such records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

_____

Signature of Patient Date