Integrity Primary Med
Patient Oriented Family Practice

Phone (239) 215-3500 Fax (239) 215-3525

10491 6 Mile Cypress Parkway, Suite 271
Fort Myers, FL 33966-6518

MEDICAL RECORDS REQUEST

TODAY'S DATE: _____

PATIENT'S NAME (printed):_____

DATE OF BIRTH: _____

I hereby authorize the release of my medical records or copies of such, including reports and/or testing associated with any previously diagnosed conditions and request they be transferred to:

INTEGRITY PRIMARY MED LLC
10491 6 Mile Cypress Parkway, Suite 271
Fort Myers, FL 33966-6518
PHONE: (239) 215-3500
FAX: (239) 215-3525
IntegrityPrimaryMed@outlook.com
Direct Messaging Address: eileen.callaway.1@26277.direct.athenahealth.com

*** ALTERNATIVELY, PLEASE ENABLE RECORD SHARING WITH ATHENAHEALTH ***

From:

_____City, State:_____

_____City, State:_____

_____City, State:_____

_____City, State:_____

_____City, State:_____

_____City, State:_____

PATIENT'S SIGNATURE:_____DATE:_____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire ONE YEAR from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by Federal Privacy Standards.

Revised 06/15/2023