

JOSEPH M. SPERDUTO, M.D., P.A.
ANGEL FELICIANO, M.D.
250 DIXIE BLVD, SUITE 203
DELRAY BEACH, FL 33444
561-278-5615 FAX 561-278-3233

PLEASE MAIL RECORDS IF OVER 10 PAGES

****If over 10 pgs. upload to our website: www.jmsmd.com, scroll down at the bottom you will see instructions****

AUTHORIZATION TO RELEASE MY HEALTH INFORMATION

I, _____, authorize _____
(Patient's name) (Physician/Facility)

I hereby request that my medical records be sent to Dr. Joseph M. Sperduto.

All my health information for the past 3 years; All my health information

My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

Other: _____

The following items must be initialed to be included in the use or disclose of other health information:

____ HIV/AIDS related health information and/or records

____ Mental health information and/or records

____ Drug/alcohol diagnosis, treatments, and/or referral information (Federal regulations require a description Of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of Such information).

The information contained in this authorization and any document attached to it is confidential and may be legally privileged. It is intended solely for the use of the addressee. Access to this information by anyone else is unauthorized. Medical records are not to be distributed to any other physician, attorney, party, etc until you contact Dr. Joseph M. Sperduto's office to obtain a written authorization.

If you are not the intended recipient, you are hereby notified that any disclosure, discrimination, duplication or distribution of this information is strictly prohibited and may be unlawful.

If you are not the intended recipient, please:

- Destroy all copies of this message.
- Notify our office immediate at the number listed above

Patient Signature

Date

Patient Name

Date of Birth