Richard L. Van Buskirk, D.O.
1217 S East Ave., Suite 310
Sarasota, FL 34239
941-924-1729

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS. PLEASE COMPLETE THE ENTIRE FORM.

****This notice informs us on how you would like your medical information disclosed. PLEASE READ CAREFULLY**.

Patient Name: _____ Date of Birth: _____

Do we have your permission to?

Send appointment reminders to your home Y or N
Text you with appointment reminders Y or N
Phone number for text messages: _____
Email you with appointment updates/changes Y or N
Please give us your email address: _____

Do we have permission to leave the following on your home answering/voice mail?

Appointment information? Y or N
Billing information? Y or N
Medical information? Y or N

I give permission to share billing, appointment and medical information with the person(s) listed below:

Name _____ Relationship _____
Name _____ Relationship _____

That if and when it is medically appropriate or necessary for my care my medical records from this office may be released to other physicians and my medical insurer.

- I understand that my medical records may contain information about but not limited to alcohol and/or drug treatment, mental health or psychiatric, and/or HIV/AIDS information. I do expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need indicated above.
- I understand that certain records may be sent via fax and I relieve Sarasota Osteopathic Medicine employees, and/or agents any liability from mis-transmission by fax.
- A photocopy of this authorization shall have the same effects as the original.

Patient Signature Date