South Florida Endocrine Center STAT___

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Jupiter, FL. 33458

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Phone (561)626-9041
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Authorization to Obtain Health Records

- Dr. Aleksandra Kraeher, MD
- Dr. Alan Feldman, MD, FACE, ECNU
- Dr. Kenilia Ventura, MD
- Dr. Gracielena Rodriguez, MD
- Dr. Monica Munoz, DO

PLEASE PRINT CLEARLY

PATIENT NAME: _____ DOB: _____

SERVICE DATES: FROM _____ TO _____ OR MOST RECENT_____

I hereby authorize: _____ FAX: _____
To release the medical records requested for continuity of care.

- PROGRESS NOTES
- RADIOLOGY REPORTS
- LAB REPORTS
- PATHOLOGY REPORTS
- ALL RECORDS
- OTHER:_____
  _____

I understand that pursuant to Florida Law and the Health Insurance Portability and Accountability Act of 1996 HIPAA privacy rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this request. Charges are in compliance with the Florida Law. I understand that once my information is disclosed to the recipient above it may be re-disclosed to individuals not subjected to HIPAA, and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing to the address listed above provided that the information has not already been released.

PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZED PERSONS SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: PARENT OR LEGAL GUARDIAN ◯ LEGAL REPRESENTATIVE ◯ OTHER ◯