



REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

Name and Address of Practitioner

To be sent to:

Florida Oncology Tavares
2010 Nightingale Lane
Tavares, Florida 32778
Phone 352-742-3045 Fax 352-742-3169

Table with 2 columns: Item (checked) and Item. Rows include Office Visit Note, Pathology Report, Operative Report, Discharge Summaries, CT scans and reports, MRI films and reports, Bone scan films and reports, Lab Results, Radiation Treatment Records, Simulation/Port Films. Includes an 'Other:' section at the bottom.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Oncology Tavares to receive copies of any medical, psychiatric, Aids, Aids relates syndromes, HIV testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire ninety (90) days after the date below or sooner at my election.

Print Patient Name

Date of Birth

Signature Patient, Parent or Legal Guardian/Representative

Date