Kathy L. Anderson, DO, PA

510 E. Druid Road, Suite A ~ Clearwater, Florida 33756 ~ (727) 462-5242 ~ Fax (727) 462-5350

Authorization for Release of Medical Records

I authorize the following protected health information to be released from the medical record of:

_____ _____
PATIENT NAME (PLEASE PRINT) DATE

_____ _____
PHONE NUMBER DATE OF BIRTH

Release Records: ❒ To ❒ From

Kathy L. Anderson, DO, PA
510 E. Druid Rd, Suite A
Clearwater, Florida 33756
(727) 462-5242 Fax: (727) 462-5350

Release Records: ❒ To ❒ From

_____
Name/Organization

_____
Address

_____
City State Zip Code

_____
Phone Fax

❒ Please mail my records ❒ Please call when my records are ready for pick-up ❒ Please fax my records

I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under Federal or Florida privacy law, the information may no longer be protected by Federal and Florida privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

- ❒ Complete Records
- ❒ Lab Reports
- ❒ Operative Reports
- ❒ History & Physical
- ❒ Radiology Reports
- ❒ Hospital Reports
- ❒ Progress Notes
- ❒ Pathology Reports
- ❒ Medication Record
- ❒ Care Plan
- ❒ Treatment Record
- ❒ Other (please specify below)

REASON FOR RELEASE OF INFORMATION:
❒ At the request of the individual
❒ Other (DESCRIBE REASON FOR DISCLOSURE) _____

_____ _____
SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE) DATE

I have verified the patient's identification:

_____ _____
PRACTICE REPRESENTATIVE DATE

Date Released: _____ Released by: _____

Notes: _____