Palms Medical Group
Your home for health, wellness, life

Medical Records Release Authorization

Please complete all sections of this form. Sign and return to:
Palm Medical Group, 911 S. Main Street, Trenton, FL 32693 ● Phone: 352-463-2374 FAX: 352-463-2726

1. Patient Identification

Date of Birth:	**PMG Location:**		**Provider Name:**
Legal Name:	**First:**	**MI:**	**Last:**
Address:	Street Address:		Apartment No.:
	City:	State:	Zip Code:
Email:		**Sign up for Patient Portal?** ☐Yes ☐No ☐ Already Signed up	
Cell Phone:		**Home Phone:**	

2. Release Records To/From

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment or health insurance enrollment or eligibility of benefits.

Delivery Method:	**RECORDS TO:**	**RECORDS FROM:**
☐ Mail ☐ Fax ☐ E-Mail ☐ Pick up in person	**Name/Agency:**	**Name/Agency:**
	Address:	**Address:**
	City: **State:** **Zip:**	**City:** **State:** **Zip:**
	Phone: **Fax:**	**Phone:** **Fax:**

3. Information Requested *(Fees may apply)*

☐ **Abstract of Medical Records for 2 years** *(Face sheet H&P, Discharge Summary, Consult Reports, Operative Reports, Pathology Reports, Cardiology Reports, Lab Reports, Imaging Reports and Emergency Room Reports)*

☐ Last 2 Office Notes	☐ Immunizations	☐ Last Cardiology/EKG Reports	☐ Last Radiology/X-ray/MRI Reports
☐ OB/GYN Notes	☐ Last PAP Note	☐ Last Mammogram Report	☐ Other
☐ Mental Health/Psychiatric Treatment		☐ STD/HIV/AIDS Treatment or Tests	

4. Purpose of Request

☐ Litigation	☐ Continuity of Care	☐ Insurance	☐ Personal Copy/Self
☐ Disability/SSI	☐ Workers Comp	☐ Other	☐ Transfer of Care *(permanently leaving PMG)*

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.
REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to Palms Medical Group.

In Addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other persons.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- **I have read all of this form and agree to the disclosures above from the types of sources listed.**

Signature: **Date:**

Printed Name of Legal Representative: **Date Signed:**

If other than patient, indicate relationship: ☐Parent of Minor ☐Guardian ☐Other (explain): _____

Board Approved: October 18, 2018