Phone: 850-588-1066 Fax: 850-588-1036
Email: fwgprovider.tm@gmail.com
Address: 12111 Panama City Beach Parkway
Panama City Beach, FL 32407

Medical Records Release Form

Patient Name:_____D.O.B_____
SSN:_____/_____/_____ Address:_____

Requesting Records from:

Name:_____
Address:_____
City,State,Zip:_____
Phone Number:_____ Fax:_____

The information you may release subject to this signed release form is as follows:

_____ Complete Records _____ Physician Notes

_____ Imaging Reports _____ Registration Records

_____ Lab Results Dates of Treatment (if applicable) _____ to _____

Purpose for Release of Records:

_____ Changing Physicians _____ Moving

_____ Attorney _____ Personal Reasons/Other

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, and/or a summary/narrative of my protected health information, to the physician/person/facility listed above.

_____ _____
Patient Name Printed Name of Personal Representative

_____ _____
Patient Signature or Personal Representative Relationship to Patient (if applicable)

_____
Date