

Release of Medical Records

Printable Form

Date: _____

I request that:

Physician's Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Release any and all medical records and send them to:

Physician's Name: Glaser Family Medical Center PLLC

Address: 1017-1019 Professional Park Dr.

City: Brandon

State: FL

Zip: 33511

Telephone/Fax: 813-643-9000/813-643-9001

I understand that these records may contain administrative and/or billing information, and I give my permission for the release of that information. I also give my permission for this material to be transmitted by telefax. I understand that it is my responsibility to provide this office with an accurate fax number if records are to be faxed. I understand that faxing records may result in transmission to the wrong fax number. I accept the risk of mis-transmission if my records are faxed and relieve this office and its agents and employees of any liability for mis-transmission by fax. I understand that this record may contain information about HIV test results. I give my permission for release of this information. This release is effective until and unless revoked in writing.

Signature: _____

Print Name: _____

Date of Birth: _____

Social Security #: _____

Please fill in, print and fax to, or bring in to Glaser Family Medical Center PLLC at your next appointment.