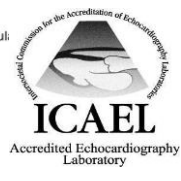


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Medical Record Request

Authorization for Use or Disclosure of Protected Health Information to third parties.
 Please note, when obtaining records from our office, it can take up to 30 days.
 Records requested for your personal use are subject to a fee.

This authorization permits Suntree Internal Medicine to:

Please Check One: **OBTAIN** information **FROM** **RELEASE** information **TO**

Name of Physician / Practice / Patient

Address

Phone Number

Fax Number

Email Address

Past Year(s) of Records Recent Labs Recent Clinical Notes
 Radiology Reports In-House Procedures H&P
 All Records Other: _____ *****Please ONLY check what is needed**

I _____ DOB _____ hereby authorize you to release all medical and surgical records of the patient referred above. The information is to include but not limited to, medical information, mental health information, personal habits, alcohol use and HIV (AIDS) results if available.

X _____
Patient Signature

Date

X _____
 Guardian Signature (provide documentation)

 Date