Fakhoury Medical and Chiropractic Center

MEDICAL RECORDS RELEASE FORM

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

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

Complete Records History & Physical Progress Notes
Care Plan Lab Reports Radiology Reports
Other_____

Release these records from:

Name: _____

Address _____

City_____State_____Zip_____

Telephone #_____Fax #_____

To Be: Faxed to (352) 629-6667 Mailed

Comments:

Please fax to our office manually. Pt is here now. Thank you!

_____

_____

Patient Information:

_____ _____
Print Patient's Name Signature of Patient

_____ _____
Patient's Date of Birth Date of request

1009 SW 16th Lane, Ocala, FL 34471
Phone (352) 351-3413 Fax (352) 629-6667