2019

Primary Care Physicians

3780 NW 83rd Street
Gainesville, FL 32606
Phone: 352-377-2022
Fax: 352-377-9113 or 352-377-9574

Records Release

Patient Name: _____ **DOB:** _____

TO BE FILLED OUT BY OFFICE STAFF ONLY	
Previous Physician/Office Name:	
Specialty:	
Phone:	Fax:
City:	State:

I hereby authorize and release the custodian of my/my dependent's medical records to Primary Care Physicians of Gainesville, including physical examination reports, laboratory reports, immunizations, diagnostic imaging reports, reports including HIV/AIDS, STD records, mental health records, and substance abuse reports. _____

Patient Initials

Release to: Primary Care Physicians of Gainesville □ Elizabeth Sanders, DO □ Abigail Eley, DNP, ARNP

3780 NW 83rd Street, Gainesville, FL 32606 Fax: 352-377-9113 or 352-377-9574

If records exceed 15 pages we request that they be mailed.* *No computer disk records.

-I understand that all medical, surgical, psychiatric and psychological information is confidential and that the patient records are the property of Primary Care Physicians of Gainesville and its related corporate entities. I will not hold Primary Care Physicians of Gainesville, its employees, staff or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.
-I understand that my authorization for release may be revoked at any time by written request to Primary Care Physicians of Gainesville, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Primary Care Physicians of Gainesville to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest your coverage.
-I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release Primary Care Physicians of Gainesville, its employees, its staff, and representatives from all liability relating to or arising out of this release of information contained Primary Care Physicians of Gainesville records.
-I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from Primary Care Physicians of Gainesville. However, if the only purpose for providing the service is to obtain in formation in order to release information to myself or a third party, then I understand that I might sign the authorization in order to receive the service.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified below.
Expiration Date or Circumstance: _____

Patient Signature: _____ **Date:** _____

Relationship to Patient if Not Self: _____

Witness: _____

Requested By: _____ Date: _____