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## **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

	MEDICAL RECORDS#
NAME OF PATIENT (Please Print)	DATE OF REQUEST
DATE OF BIRTH	SOCIAL SECURITY #
I HEREBYAUTHORIZE:TO FURNISH INFORMATION FROM THE MEDICAL RECORD(S) IN WHOLE OR IN PART, AND SUBMIT SUCH COP	
INFORMATION REQUESTED:	
THIS WILL RELEASEFROM ALL LEGAL LIABILITYTHTA MAYARISEASA RESULTOF	D.O., MD. OR HOSPITAL) THE RELEASE OFTHEABOVE INFORMATION.
SIGNATURE OF PATIENT OR PARENT, IF MINOR	DATE
SIGNATURE OF WITNESS	
I UNDERSTAND AND AGREE THAT A COPY OF HIV TES	STING DRUG/ALCOHOL SCREENING
RESULTS and/orPSYCHIATRIC RECORDS WILL BE R	ELEASED IF REQUESTED.
SIGNATURE OF PATIENT OR PARENT, IF MINOR	DATE
SIGNATURE OF WITNESS	
PATIENT'S HOME ADDDRESS AT TIME OF TREATMENT ANDIOR TESTING:	

**STREET** 

CITY, STATE AND ZIP CODE

This Information has been disclosed to you from records whose confidentiality is protected by state law. Florida Statute 381.609 prohibits you from making any further disclosure of such information wothout the specific written consent of the person to whom such information pertains. or as otherwise permitted by state law.