AUTHORIZATION FOR REQUEST/RELEASE MEDICAL RECORDS

RELEASE: Requesting information from another Provider/Practice to us

Patient Name: _____

Date of Birth: _____ Phone Number: _____

I authorize the release of my following protected health information: From: _____

_____

☐ ALL RECORDS ☐ Office Notes ☐ Radiology Reports ☐ Pathology Reports ☐ Laboratory Reports

☐ EKG ☐ Last Office Notes ☐ Other

To: ☐ Dr. Jay Shaktawat
☐ Dr. Clarissa Abrantes
☐ Dr Anis Shahmiri

☐ Health First Internal Medicine Associates
13953 NE 86th Terrace, Suite 101
Lady Lake, FL 32159

Tel: 352 633 8681 • Fax: 352 385 7574

☐ 1400 US Highway 441 North, Suite 538
The Villages,, FL 32159

The purpose of this authorization is for: ☐ Medical/Treament ☐ Other (Specify): _____

_____ _____ Patient/Representative

Signature Date

If the patient listed above is a minor or unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____ Print Name

_____ Relationship to Patient

SGF TO REORDER CALL 1.800.321.FORM