A Center for Medicine & Reconstructive Surgery of The Foot, Ankle & Lower Leg.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:________________________________ Social Security #________________

Date of Birth: ____/____/____

PURPOSE / NEED FOR INFORMATION:

( ) Application for Insurance　　( ) Changing Physicians　　( ) Personal

( ) Insurance Claim　　( ) Specialist　　( ) Other ________

I hereby authorize ____
to release the following information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me from (dates of treatment) ______________________________:

( ) Office notes　　( ) Other ______________________________

( ) Laboratory reports　　( ) X-ray reports ________________________
(specify if necessary)

Forward Documentation To:

( ) Dr. Christopher C. Mason
4106 W. Lake Mary Blvd. #125 Lake Mary, Florida 32746 Fax: 407-333-0219

OR

( ) ____
(If requested to be sent to patient or other medical facility)

This request is authorized to include any federal and/or State protected information under Florida Statues 394.459 (9) Psychiatric Information, 397.053/396.112 Drug and/or Alcohol Abuse Information, 381.609 HIV and Aids related conditions and/or 397.501 (3) records of a minor client.
I understand that this authorization will expire 90 days from the date of signature below or when acted upon, whichever event occurs first. I herby release to the forwarding addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

_________________________　　_________________________
(Signature or parent/guardian)　　(Date)

_________________________　　_________________________
(Relationship to patient)　　(Witness)

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