PRIMARY CARE SPECIALISTS OF FLORIDA
721 W COLONIAL DR
ORLANDO, FL
ZIP 32804
Tel: (407) 735-6735
Fax: 1-855-618-2347
www.pcsfmed.com

(PLEASE PRINT)
Patient's Legal Name:_____

Patient's Nickname:_____ Age:_____ Birthdate:____/____/____

Address: _____

City, State, Zip Code:_____ Phone #:(____)_____

Records to Request or Release:

- ___ Complete Office Record
- ___ Hospital Hospital Record
- ___ Emergency Room Record
- ___ History and Physical Examination
- ___ Consultation Report
- ___ Progress Notes
- ___ Discharge Summary
- ___ Operative Report
- ___ Lab and X-ray Reports
- ___ Doppler Report
- ___ Other (specify)

_____
_____
_____
_____
_____

Reason for Release:

- ___ To update my Primary Care Provider
- ___ I want/need a second opinion
- ___ I am changing doctors due to:
  - ___ Insurance change
  - ___ Dissatisfaction with care
  - ___ Moving to a new address

_____
_____
_____

___ Other_____

Date(s) of Service:____/____/____ to present

I understand that Primary Care Specialists of Florida may refuse health care services to me if I fail to sign an authorization. I understand that I may Revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will automatically expire after six (6)months from the date it is signed.

REQUEST FROM

This authorization gives my permission and consent to REQUEST from the following described facility,those medical records and test results checked above regarding medical treatment and care that I have received at such facility:

Facility Name:_____
Address:_____
City, State, Zip:_____
Phone:(____)_____ Fax:(____)_____

Mail or Fax to: 855-618-2347
Primary Care Specialists of Florida
721 W. Colonial Drive
Orlando, Fl 32804

RELEASE TO

This authorization gives my permission and consent to RELEASE those medical records and test results checked above regarding medical treatment and care that I have received from Primary Care Specialists of Florida to the following:

Name:_____
Address:_____
City, State, Zip:_____
Phone:(____)_____ Fax:(____)_____

I understand that Primary Care Specialists of Florida is not responsible for uses or disclosures of my medical information by the above party and that There is the potential for such party to further disclose my medical information in a way that it would no longer be protected by privacy laws.

_____
Date

_____
Signature of Patient or Authorized Representative

_____
Physician's Signature of Consent

Date Completed:____/____/____