Request Release of Medical Records

2401 University Parkway, Suite 104, Sarasota, Fl 34243 Phone: 941-357-1773 Fax: 941-256-7452
8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 Phone: 813-544-3123 Fax: 941-256-7452
20754 West Dixie Highway Miami, FL 33180 Phone: 786-855-4800 Fax: 941-256-7452

To **(Providing Facility/Location):**_____

Phone Number: _____ Fax Number: _____

_____ ____/____/____ ____-____-____
Patient Name **Date of Birth** **SSN**

I Request That Records Be Released That Pertain to The Following Body Region(s):

_____

Specifically, I Request for The Following to Be Sent:

- ____ **X-Rays (Radiology Report and Imaging Disk)**
- ____ **Mri's (Radiology Report and Imaging Disk)**
- ____ **Consult Reports**
- ____ **Operative Reports**
- ____ **Complete Records**
- ____ **Other** _____

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☐ 20754 West Dixie Highway Miami, FL 33180 Phone: 786-855-4800 - **Fax: 941-256-7452**

Requesting Provider:

☐ **James Leiber, D.O.** ☐ **Ronald Torrance, D.O.** ☐ **Evan Musman, D.O.**
☐ **Ignatios Papas, D.O.** ☐ **Michael Amoroso, M.D.**

I authorize your facility to release the medical records requested to Regenexx Tampa Bay and/or Regenexx Gold Coast.

_____ ____/____/____
Patient Signature **Date**

I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice. **I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice.**