**11301 Countryeay Blvd. – Tampa, FL 33626**
**Phone 813.855.8450 – Fax 813.855.7540**
**www.westchasesportsmedicine.com**

## Medical Records Release Authorization

**In order to avoid a delay this form must be completed in its entirety.**
**PLEASE PRINT CLEARLY**

Patient Name:_____ Maiden Name:_____

D.O.B. **(Required)**_____ SS#**(Required)**_____

Home Phone:_____ Work Phone: _____

Permission is hereby granted to Westchase Sports Medicine to release medical information to the individual/organization as noted below or to have records released to Westchase Sports Medicine:

☐ Mail to: Name:_____

Address:_____

City/State/Zip:_____

☐ Fax to another medical entity (____)_____ ☐ call when ready for pick up (____)_____ ☐ Person picking up records

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ Surgical Records
☐ Therapy reports
☐ Diagnostic test results
☐ Other _____
☐ Office Notes only
☐ X-ray/MRI films
☐ X-ray/MRI reports
☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner._____
Date

I understand I have the right to refuse this authorization, in writing, and Westchase Sports Medicine is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date