Trinity Family Physicians

Let Our Family Care for Yours
Amir Shirmohammad, MD, MPH Stephanie Eldridge, MD, MPH
1817 Cypress Brook Drive, Suite 101
Trinity, FL 34655
Phone (727) 834 – 8377 fax (727) 834 – 8371

AUTHORIZATION TO OBTAIN / RELEASE MEDICAL RECORDS

I, _____ for _____
Name of Patient / Guardian Name of Patient

Date of Birth _____ Social Security Number _____

give authorization for Trinity Family Physicians to release to and / or obtain my protected health information / medical records from the following Physician and / or facility.

_____
(Name / Physician / Facility / Agency / Organization)

_____
(Complete Address)

_____
(Phone Number / Fax Number)

The purpose of the use or disclosure is (please check all that apply) :

_____ Continued Patient Care	_____ Attorney / Legal	_____ Social Service / Disability
_____ Insurance	_____ Personal Use	_____ Patient Transferring PCP
_____ Patient Moving	_____ Other:	_____ Other:

Please ONLY send LAST "2" years of the following records: OFFICE NOTES, PROBLEM LIST, IMMUNIZATION RECORDS, PERTINENT LABS, IMAGING and DIAGNOSTICS REPORTS

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials or check mark on the lines below authorize the release (if applicable) of information pertaining to:

(_____) Alcoholism and / or Drug Abuse
(_____) Mental Health and / or Rehabilitation
(_____) HIV / AIDS / Sexually Transmitted Disease & testing for other communicable diseases

I understand that this information will be used solely for professional purposes, will remain confidential and may not be discloses to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance thereon. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

_____	_____	_____
Print Patient Name	Signature of Patient/Guardian	Date
_____	_____	_____
Print Witness Name	Signature of Witness	Date