NW FL Clinical Research Group, LLC
400 Gulf Breeze Pkwy, Suite 203
Gulf Breeze, FL 32561
850-934-1299

CR Group
Northwest Florida Clinical Research Group, LLC

Authorization to Release Medical Records

Name of Patient ____
Last First MI

Date of Birth ___________ Social Security #: ___________ Date(s) of Service _________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

INFORMATION TO BE RELEASED OR ACCESSED:

_____Clinic Notes
_____Operative Reports
_____Lab/Path Reports
_____Consultation Report
_____Discharge/Death Summary
_____X-Ray Reports/Images
____Emergency Room Record
____Face Sheet
____Other: _______________

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

I authorize and request:

____
Name of Clinic/Institution

____
Address

____
City State Zip

____
Phone

____
Fax

To release to:

NW FL Clinical Research Group, LLC
Name of Clinic/Institution

400 Gulf Breeze Pkwy, Ste 203
Address

Gulf Breeze FL 32561
City State Zip

850-934-1299
Phone

850-934-1340
Fax

_____I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

_____I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire indefinitely from the date of my signature, unless I revoke the authorization.

____ _________________
Signature of Patient/Parent/Guardian Date

____ _________________
Witness or Staff Signature Date