MARK A. LUPO, M.D.
THYROID & ENDOCRINE CENTER OF FLORIDA

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

☺ ***Please print clearly so information is legible.***

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

I hereby authorize _____
(Name of Facility or Physician)

to disclose records obtained in the course of my evaluation and/or treatment to: *(complete address please)*

_____

_____

_____

I understand that I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for The Thyroid & Endocrine Center of Florida to inform the requestor that portions of the record have been withheld.

Unless otherwise indicated below, my signature authorizes the release of all medical records without exception, including any information concerning AIDS or AIDS testing, psychological or psychiatric treatment, and/or alcohol or drug abuse.

_____

_____

_____

This consent is subject to written revocation by the undersigned at any time except to the extent that action has already been taken. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

The Thyroid & Endocrine Center of Florida reserves the right to charge a $1 per page fee for copying of medical records (i.e., in cases of extensive medical records). If a fee is to be assessed, the patient will be informed of the total cost before medical records copies are made.

Signature of Patient*: _____ Date: _____

Signature of Witness: _____ Date: _____

If signed by other than the patient, indicate relationship: _____

**Legal representatives must submit copies of legal documents supporting assignments of this authority.*