



CONCIERGEmedical
SERVICES

PRICE & TRAVNICEK

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Dr Bart Price, 1250 S Tamiami Trail, Suite 301, Sarasota, Florida. 941-365-1321/Fax 941-365-4071 upon request in person or by mail to the address specified at the time of the request.

Provider: (name & address)	Patient:
	SS#:
	DOB:

RECORDS AUTHORIZATION TO BE RELEASED:

<input type="checkbox"/> Admission history and physical <input type="checkbox"/> Discharge summary <input type="checkbox"/> Complete hospital chart <input type="checkbox"/> Office notes <input type="checkbox"/> Outpatient records <input type="checkbox"/> Psychiatric and other mental health records <input type="checkbox"/> Records relating to drug or alcohol abuse <i>(must specify the extent or nature of the records to be released)</i> <input type="checkbox"/> Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me <i>(These records should be redacted to protect information pertaining to other patients.)</i> <input type="checkbox"/> Other <i>(specify)</i> _____ Extent or nature of records to be released: <i>(example, specific hospitalization or visit)</i> _____ _____ _____
--

This information will be used for the purpose of:

<input type="checkbox"/> Investigating an allegation of abuse <input type="checkbox"/> Providing advocacy services <input type="checkbox"/> Other activities at the request of the individual	<input type="checkbox"/> Verifying my eligibility for services offered by the: _____ <input type="checkbox"/> Legal representation
---	--

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the _____, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Representative **Signature** Date

Name of Representative

Relationship to Patient

**After you have completed filling in this form, print, sign, scan and email to: JMarinelli@manasotamed.com
OR print, sign and mail to: 1250 South Tamiami Trail, Sarasota, FL 34239.**