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 Petra Travnicek, 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:

- ❑ Admission history and physical
- ❑ Discharge summary
- ❑ Complete hospital chart
- ❑ Office notes
- ❑ Outpatient records
- ❑ Psychiatric and other mental health records
- ❑ Records relating to drug or alcohol abuse *(must specify the extent or nature of the records to be released)*
- ❑ 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
  (These records should be redacted to protect information pertaining to other patients.)
- ❑ Other *(specify)* _____

_____

Extent or nature of records to be released: *(example, specific hospitalization or visit)* _____

_____

_____

This information will be used for the purpose of:

- ❑ Investigating an allegation of abuse
- ❑ Providing advocacy services
- ❑ Other activities at the request of the individual
- ❑ Verifying my eligibility for services offered by the:
  _____
- ❑ 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.