



**CONCIERGE**medical  
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, FL 34239. 941-365-1321/Fax 941-365-4071 upon request in person or by mail to the address specified at the time of the request.

<b>Provider:</b> (name & address)	<b>Patient:</b>   <b>DOB:</b>
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### RECORDS AUTHORIZATION TO BE RELEASED:

<input type="checkbox"/> Admission history and physical <input type="checkbox"/> Discharge summary <input type="checkbox"/> Mammogram <input type="checkbox"/> Office notes <input type="checkbox"/> Outpatient records <input type="checkbox"/> Immunization records <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Lab reports <input type="checkbox"/> Radiological reports <input type="checkbox"/> Consultation notes or reports <input type="checkbox"/> Bone density report <input type="checkbox"/> Colonoscopy with pathology
Extent or nature of records to be released: (example, specific hospitalization or visit) _____ _____ _____	

***This information will be used for the purpose of Continuity of Care.***

**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 S Tamiami Trail, Suite 301, Sarasota, FL 34239**