MARK C. STINE, D.O.
KIMBERLY A. DEAN, D.O.
NICHOLAS Z. OKESON, D.O.
JASON H. HOWARD, D.O.
13787 BELCHER ROAD SOUTH
SUITE 100
LARGO, FL 33771

PHONE: (727) 535-9899 FAX: (727) 535-2818

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

MEDICAL RECORDS#_____

NAME OF PATIENT (Please Print)_____DATE OF REQUEST _____

DATE OF BIRTH _____SOCIAL SECURITY # _____

I HEREBYAUTHORIZE: _____D.O., MD. OR HOSPITAL)
TO FURNISH INFORMATION FROM THE MEDICAL RECORD(S) OF THE PATIENT NAMED ABOVE, OR TO REPRODUCE THE RECORD(S) IN WHOLE OR IN PART, AND SUBMIT SUCH COPIES TO:

_____

_____

_____

INFORMATION REQUESTED: _____

THIS WILL RELEASE _____D.O., MD. OR HOSPITAL)
FROM ALL LEGAL LIABILITYTHTA MAYARISEASA RESULTOFTHE RELEASE OFTHEABOVE INFORMATION.

_____ _____
SIGNATURE OF PATIENT OR PARENT, IF MINOR DATE

_____
SIGNATURE OF WITNESS

I UNDERSTAND AND AGREE THAT A COPY OF ____ **HIV TESTING** ___ **DRUG/ALCOHOL SCREENING**

RESULTS and/or ____**PSYCHIATRIC RECORDS WILL BE RELEASED IF REQUESTED**.

_____ _____
SIGNATURE OF PATIENT OR PARENT, IF MINOR DATE

_____
SIGNATURE OF WITNESS

PATIENT'S HOME ADDDRESS AT TIME OF TREATMENT ANDIOR TESTING:

STREET

CITY, STATE AND ZIP CODE