Medical Release Form

To request the release of medical information, please complete and sign this form, and bring with you to your first appointment.

____ Release my protected health information to me.
____ Release my protected health information to:

NAME: _____

Fax: _____ _____

Email: _____

If you would like the records mailed, provide the address below.

Address: _____
Street City State Zip

Reason for release: _____

Restrictions (if any): _____

_____

I hereby authorize Ageless Medicine of the Palm Beaches (AMPB) to release my medical information as equested above. This authorization will remain active for one year from date of signature, unless revoked in writing. I am aware that AMPB cannot control how the recipient uses the information, and that laws protecting its confidentiality at AMPB may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

_____
Print Your Name

_____ _____
Your Signature Date

PLEASE FAX The Signed & Completed Form to: 561.748.8315