South Florida ElectroPhysiology
Todd J. Florin, MD

MEDICAL RECORD RELEASE FORM

Telephone: (786) 565-2400 Fax: (786) 565-2401

_____ _____
Patient Name *Date of Birth*

I hereby authorize the below listed entity to release medical information to South Florida Electrophysiology:

Name: _____ *Telephone#:* _____

Address: _____ *Fax#:* _____

_____

Medical Information Requested:

- ☐ *All Records*
- ☐ *Specific Records from* _____ *to* _____
- ☐ *Immunizations & Physical Examinations*
- ☐ *Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}*

_____ _____
Signature of Patient or Legal Guardian *Date*

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.