Release of Medical Records Request

( ) I hereby authorize: □_______________________________ to release my medical records to:

Advanced Surgical and Weight Loss Institute
3165 Suntree Blvd Suite 101
Rockledge, FL 32955
Phone: 321-549-2000
Fax: 321-549-2142

Phone:________________
Fax: ___________________

Any information including diagnostic and medical records and/or examination rendered to me during the period of _____________ to ______________ to include any and all Federal and State protected information including without limitation psychiatric, drug, and/or alcohol abuse and human immunodeficiency virus test results (Aids and related conditions).

I understand and direct that this authorization remain in effect for 180 days or until I revoke it in writing. I hereby release Advanced Surgical and Weight Loss Institute, its employees, vendors and independent contractors from any and all liability that may arise from the release of this information as I have directed.

_____________________________ ________
Signature of Authorized Personnel Date

I have reviewed and fully understand this document, and have no unanswered questions.

I have reviewed & understand this page, and have no unanswered questions.

_____________________________ ________
Patient Signature Date

Patient Name:
____

DOB:
____