

Records Release

Date: _____

To: CFP Physicians Group, P.L.
985 S.R. 436
Casselberry, FL 32707
Phone: (407) 831-5252 Fax: (407) 831-3765

I hereby authorize you to release my medical records to:

Time period requested: _____ through _____
(Date) (Date)

These records are to include any psychiatric testing, any testing for the HIV antibody and any testing for substance abuse. If you wish to exclude any from record, please specify: _____

This authorization is valid until expiration on _____ or a maximum of two years from this dated release.

X _____
(Signature)

X _____
(Witness Signature)

(Please Print Name)

(Print Name)

(Relationship to the Patient)

Patient's Name _____ Patient's Date of Birth _____

Patient's SSN: _____ - _____ - _____

WE CHARGE TO SEND RECORDS TO A NEW PRIMARY CARE PHYSICIAN OR TO RELEASE A COPY OF ENTIRE CHART TO THE PATIENT IN ACCORDANCE WITH FLORIDA ADMINISTRATIVE CODE, RULE 64B8-10.003:

REGARDING RECORDS FROM PHYSICIANS:

- No more than \$1.00 per page for the first 25 pages of written material
- \$.25 for each additional page
- Actual cost of reproducing nonwritten records such as x-rays