Brian G. Sherman, M.D.
1401 Centerville Rd., Suite 402
Tallahassee, FL 32308
Phone: (850) 671-5558 Fax: (850) 219-9741

RECORDS RELEASE

Date: _____

I hereby request the records:

From: _____

_____

To: _____

_____

Send Via (circle): Fax Mail In Person

Patient's Full Name:_____

Date of Birth:_____

Any information including diagnoses and records of any treatment or examination rendered during the period from _____ to _____.

Our notice of privacy practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our patient consent form. On occasion, the patient and the practice may want to use (PHI) for the reason other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Health Information Technology for Economic and Clinical Health Act of 2009 among other laws. The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. We assume no liability for disclosure by the receiving party.

Signature: _____ (patient or representative)

Printed Name: _____

Witness Signature:_____

Printed Name: _____