HDC
HOLLYWOOD DIAGNOSTICS CENTER
4224 Hollywood Blvd. Hollywood, FL 33021
Ph 954.966.3600 Fx 954.967.1962

MEDICAL RECORDS RELEASE FORM

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PHONE (HOME): _____ **PHONE (CELL):** _____

NAME OF DOCTOR AND/OR FACILITY YOU HAVE AN APPT WITH:

_____

DATE OF APPOINTMENT: _____ **PHONE:** _____

EXAMS REQUESTED: _____

ONLY THE PATIENT OR PATIENT'S GUARDIAN MAY SIGN AND PICK UP RECORDS AND/OR A CD. IF YOU WISH TO HAVE ANOTHER PERSON OR FAMILY MEMBER PICK UP YOUR MEDICAL RECORDS AND/OR CD, PLEASE SPECIFY THE INDIVIDUAL'S NAME BELOW AND PROVIDE YOUR SIGNATURE.

YOU OR YOUR DESIGNATED PARTY MUST BRING A PHOTO IDENTIFICATION. WITHOUT THIS INFORMATION, YOUR RECORDS WILL NOT BE RELEASED.

YOUR SIGNATURE BELOW INDICATES YOUR AUTHORIZATION TO RELEASE MEDICAL RECORDS. THESE ARE YOURS TO KEEP. ADDITIONAL COPIES MAY BE AVAILABLE FOR AN ADDITIONAL CHARGE.

FOR ATTORNEY REQUESTS, MEDICAL RECORDS AND/OR CD MUST BE PAID FOR PRIOR TO RELEASE. AN AUTHORIZATION FORM OR SUBPOENA SIGNED BY THE PATIENT MUST BE OBTAINED AND WILL BE KEPT BY OUR OFFICE.

_____ _____
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN **DATE**

I HEREBY AUTHORIZE _____ **TO PICK UP MEDICAL RECORDS ON MY BEHALF.**

_____ _____
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN **DATE**