ZAMPOGNA HEALTHCARE

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital, Health Care Provider) to release medical records:

» FROM (Name of Health Care Provider Office Releasing Records):

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Approximate dates of service: _____ to _____

OFFICE USE ONLY

□ Abstract Summary (2 yrs. office visits/labs/imaging/hospitalizations)

□ Office Visits: _____ □ Diagnostic Tests: _____ □ Medication List

□ Lab Results: _____ □ History & Physical □ Immunization Record

□ Hospital Records: _____

» TO (Name of Requesting Party):

□ Zampogna Healthcare
1350 Tamiami Trl. N. Ste. 205
Naples, Florida 34102

Tel (239) 263-1910
Fax (239) 263-5424
info@zampognahealthcare.com

PURPOSE OF RELEASE OF MEDICAL RECORDS

□ Change in primary doctor □ Other (specify): _____

The Undersigned hereby releases Zampogna Healthcare from any and all legal responsibility or liability that could occur from this action.

PATIENT SIGNATURE _____ Date _____