Authorization to Release Medical Records

Provider: Dr. Jessica Crivelli

Patient Name					
Social Security Number **Please enter below**			Date of Birth		
			Month	Day	Year
Name of Physician:					
City, State					
Tel. #					
Fax #					

Dear Doctor;
Please release my medical records related to treatment for services rendered by you or under your supervision. This information will be used to further assist in my medical care, and should be faxed to:

352-684-1420

Thank you!

Patient Signature		Date
Guardian Signature		Date
Witness Signature		Date

Please Release my Records as indicated below

X	**Last Examination**
X	**SOAP Notes**
	Complete : Any and All Medical Records
	Medical Reports
	X-Rays
	Diagnostic Imaging Reports
	Specific Records as listed below
	Dates
	Condition
	Treatment
	HIV / AIDS Status
	Alcohol / Drug Status
	Psychological/Mental Evaluation/Treatment
	Other :

14270 Spring Hill Drive, Spring Hill, FL 34609
352-684-1484 Fax: 352-684-1420