North Florida Center for Otolaryngology
head & neck surgery
facial plastic surgery, pa

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NORTH FLORIDA CENTER FOR FACIAL PLASTIC SURGERY

Towne Centre
FOR DERMATOLOGY

MEDICAL RECORDS RELEASE FORM

PATIENT NAME: _____ DATE: _____

ADDRESS: _____

DATE OF BIRTH: _____ S.S. #: _____

I HEREBY AUTHORIZE DR. TALIAFERRO/DR. LEAKE/DR MILLER/DR TOWNE AND/OR STAFF TO:

☐ RELEASE ANY AND ALL MEDICAL RECORDS TO MYSELF (PATIENT)

☐ RELEASE ANY AND ALL MEDICAL RECORDS AS DEEMED NECESSARY FOR MY TREATMENT TO THE FOLLOWING PHYSICIAN'S OFFICE:

☐ OBTAIN ANY AND ALL MEDICAL RECORDS AS DEEMED NECESSARY FOR MY TREATMENT FROM THE FOLLOWING PHYSICIAN'S OFFICE:

PHYSICIAN NAME: _____

PHONE #: _____ FAX #: _____

Dear Doctor: In order for us to fully evaluate this patient's health and make informed decisions, please send all relevant medical records in your file including x-ray films and reports. Please send/fax records to our office at your earliest convenience to:

3 San Bartola Drive
St. Augustine, FL. 32086
Fax #: 904-808-8587

Thank you for expediting this request.

Additional Comments: _____

_____

PATIENT'S SIGNATURE (PARENT IF PATIENT IS A MINOR):

_____ DATE: _____

SIGNATURE OF WITNESS: _____

DATE FAXED/SENT: _____ INITIAL: _____