TRENTON MEDICAL CENTER, INC.

Trenton Medical Center
911 South Main Street
P.O. Box 640
Trenton, FL 32693
Phone: (352) 463-2374
Fax: (352) 463-2726

Bell Family HealthCare
1830 North Main Street
P.O. Box 639
Bell, FL 32619
Phone: (352) 463-1100
Fax: (352) 463-3924

REQUEST FOR RELEASE OF MEDICAL INFORMATION TO TRENTON MEDICAL CENTER, INC.

IF THERE IS A CHARGE FOR MEDICAL RECORDS PLEASE CONTACT
MEDICAL RECORDS CUSTODIAN AT 352-463-4516.

PATIENT'S NAME: _____

SS#: _____ DATE OF BIRTH: _____

Please release my records to the facility marked below:

{ } Trenton Medical Center
PO Box 640
Trenton, Florida 32693
Fax: 352-463-2726

{ } Bell Family Healthcare
PO Box 639
Bell, Florida 32619
Fax: 352-463-3924

{ } Trenton Pediatrics
PO Box 640
Trenton, Florida 32693
Fax 352-463-6271

I authorize (Facilities Name): _____
Address: _____
_____, to furnish any and all medical records in its possession regarding the above named patient. I specifically consent to the release of any information contained in the medical record which may relate to psychiatric illness and treatment; results of Human Immunodeficiency Virus (HIV) testing, or treatment of AIDS related illnesses; STD's; TB; Adult and/or Child Abuse; Drug or Alcohol Abuse or treatment. Any restrictions on this authorization are listed below: _____
_____

The purpose(s) of obtaining this information is:[ ] Treatment, Payment, Health care operations [ ] Other: Please explain: _____

I understand that this authorization will remain in effect for the next twelve (12) months. Unless revoked in writing.

I authorize Trenton Medical Center, Inc., to forward to other healthcare providers any information received from former Health Care Providers when this information is needed in order to facilitate specialty referrals being made on my behalf.

I hereby release Trenton Medical Center, Inc., the employee's and associated healthcare providers from any liability that may arise from the release of information as I have directed.

I authorize you to transmit this information by facsimile transmission (fax).

Signature: _____ Date: _____
If signed by other than patient, relationship to patient: _____

Witness Signature: _____ Date: _____

Dedicated To Meeting The Health Care Needs Of Their Community Since 1971