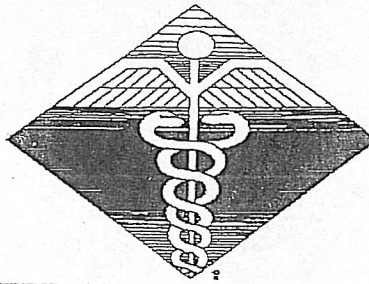


# TRENTON MEDICAL CENTER, INC.

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: \_\_\_\_\_