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

PATIENT'S NAME:_____

SS#:_____DATE OF BIRTH:_____

Please release my records to the facility marked below:

{ } Trenton Medical Center P. O. Box 640 Trenton, FL 32693 Fax : 352-463-2726	{) Bell Family Healthcare P. O. Box 639 Bell, FL 32619 Fax: 352-463-3924	{ } Trenton Pediatrics P. O. Box 640 Trenton, FL 32693 Fax: 352-463-6271	{ } Branford Health & Wellness P. O. Box 328 Branford, FL 32008 Fax: 386-935-3198

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 the release of any treatment; results of Human Immunodeficiency Virus (HIV) testing, or treatment of AIDS related illness; 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: _____