FLORIDA CANCER SPECIALISTS & Research Institute

# REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

Cancer Specialists of North Florida

- ☐ **Baptist South** | 14546 Old St Augustine Rd, Suite 317, Jacksonville, FL 32258
- ☐ **Fleming Island** | 2370 Market Drive, Fleming Island, FL 32003
- ☐ **St Vincent's, Clay** | 1658 St Vincent's Way, Suite 230, Middleburg, FL 32068

**To be sent to Florida Cancer Specialists:**

Mail to: 4689 US Highway 17, Suite 2, Fleming Island FL. 32003 **OR**

Fax to: **1-844-202-1325**

Phone – 904-269-6526

_____ I give permission to Fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Cancer Specialists to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

_____ _____

Print Patient Name Date

_____

Patient Date of Birth

_____ _____

Signature Patient, Parent, or Legal Guardian/Representative Date