Medical Records Release Form

Date: _____

Patient Info:

Full Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Date of Birth: _____

FORMER Medical Provider's Information:

Name: Beach Health Center, LLC

Address: 16517 Vanderbilt Dr, Suite 3, Bonita Springs, FL 34134

NEW Medical Provider's Information:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Records Subject To Release:

» Office Notes
» Diagnostic Results
» Lab Results

RE: Medical Records Release Authorization

I, _____ hereby authorize the release of my medical records to

_____ for the purpose of new patient establishment.

(New provider name)

Patient Signature: _____

Email Completed Form

FAX: 239-319-0089 | MAIL: Elizabeth Ulman, 10260 Strike Lane, Bonita Springs, FL 34135