MEDICAL RECORDS RELEASE FORM

To request the release of medical information, please complete and sign this form and fax it to (561) 658-6212.

☐ Release my protected health information to me.

Or

☐ Release my protected health information to,

Name: _____

Fax: _____ Phone: _____

Email: _____

If you would like the records mailed, provide the address below.

Address: _____
Street City State Zip

Reason for release: _____

Restrictions (if any): _____

_____

I hereby authorize Andrologix Health and Wellness LLC. (Andrologix), to release my medical information as requested above. This authorization will remain active for one year from date of signature, unless revoked in writing. I am aware that Andrologix cannot control how the recipient uses the information, and that laws protecting its confidentiality at Andrologix may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

_____
Print Your Name

_____ _____
Your Signature Date