BALANCED REJUVENATION
INTEGRATIVE MEDICAL CENTER

Authorization for Release of Protected Health Information

I. I, ____, date of birth ____/___/_____, hereby request and authorize the release of records

II. FROM: (NAME of Provider Releasing Records) ____

(Address) ____

____

(Phone #) ____

(Fax #) ____

III. TO : Dr. Deanna Ohms

Balanced Rejuvenation Integrative Medical Center, PLLC

7321 Dr. MLK Jr. Street N

St. Petersburg, FL 33702

727-522-1972 (P)

PLEASE SEND RECORDS VIA: _______ 1. MAIL RECORDS TO THE ADDRESS ABOVE

_______ 2. FAX 727-877-3447

IV. PLEASE RELEASE THE FOLLOWING RECORDS:

☐ All Medical Records

☐ Limited Records as follows (specify type of records or date of service): ___________________________

____

☐ I consent to releasing records even if they contain information regarding Mental Health/Drug/Alcohol Abuse, HIV/AIDS/STD/Genetic Testing

V. RECORDS ARE FOR THE PURPOSE OF:

☐ Continuing Medical Care

☐ Information for Insurance Company

☐ Information for Attorney

☐ Personal Use, at the request of the patient

☐ Other (Please Specify): ____

VI. AUTHORIZED BY (Signature of Patient/Legal Representative):____________________________________DATE ________

(Printed Name): ____

***Please note that records will only be released within accordance of the law. It is the patient's right to revoke this release at any time. In accordance with Florida State Law, fees will be assessed for any records released other than ONE copy sent to another care provider for continuation of care.*