



Authorization for Release of Protected Health Information

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

II. FROM: Balanced Rejuvenation Integrative Medical Center, PLLC
7321 Dr. Martin Luther King Jr Street N
St. Petersburg, FL 33702
(P) 727-522-1972
(F) 727-877-3447

III. TO : Send Records to : (Choose One Only:)
☐ New Provider:
☐ Patient/Self:
☐ Other:

(Name) _____

(Address) _____

(Phone #) _____

IV. PLEASE SEND RECORDS VIA: _____ 1. MAIL RECORDS TO THE ADDRESS ABOVE
_____ 2. FAX: _____
_____ 3. Email: _____

V. 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

VI. 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): _____

****Please be advised that records released directly to patient and/or new provider will only be done ONE TIME ONLY.***

VII. 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.***