Medical Records Request Form

By signing this form, I authorize Florida Concierge Medicine & Wellness LLC to **REQUEST** confidential health information about me, by requesting a copy of my medical records, or a summary or narrative of my protected health information from the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

The information requested is as follows:

_____

_____

_____

Initial next to each selection to also include:

_____ Mental Health Information

_____ Genetic Testing Information

_____ HIV/AIDS Information

_____ Substance Abuse Diagnosis/Treatment

Request my protected health information **FROM** the following physician/person/facility/entity:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name Description of Personal Representative

SEND records to:
Florida Concierge Medicine & Wellness
Fax: 954-361-7994
Phone: 954-932-FCMW
Email: info@FloridaConciergeMed.com
5555 Hollywood Blvd, Suite 201
Hollywood, FL 33021