AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Please Fax Records to 941-795-1400)

I, _____ DOB: _____ / _____ / _____

(Patient's Name)

Hereby authorize Kate Ross M.D and Associates to: (check one option)

( ) release copies of my medical records

( ) obtain all my records

For the purpose of fully evaluating my health and to make informed decisions. Please include the following protected information in addition to my general health information: (check applicable option)

( ) All labs, imaging studies, and records

( ) Pathology

( ) Photos

( ) All Available medical records

TO/FROM: (circle one option)

_____

Patient Signature: _____

Date: _____