Richichi Family Health

PELICANPRIMARYCARE

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Name: (Last, First, MI) _____

Address: _____

Phone: _____ Date of Birth: _____

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital, Health Care Provider) to release medical records:

» **FROM** (Name of Health Care Provider Office Releasing Records):

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Approximate dates of service: _____ to _____

******OFFICE USE ONLY******

☐ Abstract Summary (2 yrs. office visits/labs/imaging/hospitalizations)

☐ Office Visits: _____ ☐ Diagnostic Tests: _____ ☐ Medication List

☐ Lab Results: _____ ☐ History & Physical ☐ Immunization Record

☐ Hospital Records: _____

» **TO** (Name of Requesting Party):

☐ *Richichi Family Health*
1217 Piper Blvd Ste 101
Naples, FL 34110
PH: (239) 514-2005
Fax: (239) 236-7959 – dedicated fax
info@richichihealth.com

☐ **PELICAN** PRIMARY **CARE**
23421 Walden Center Dr Ste 100
Bonita Springs, FL 34134
PH: (239) 514-2008
Fax: (239) 236-7959 – dedicated fax
info@pelicanprimarycare.com

PURPOSE OF RELEASE OF MEDICAL RECORDS:

☐ Change in family doctor ☐ Other (specify): _____

The Undersigned Hereby Releases RICHICHI FAMILY HEALTH/PELICAN PRIMARY CARE from Any and All Legal Responsibility or Liability that could occur from this Action.

Patient Signature: _____ **Date:** _____