PELICANPRIMARYCARE

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Name: (Last, First, MI) _____

Address: _____

Phone: _____ Date of Birth: _____ SS#: _____

AUTHORIZATION:

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

From (Name of Health Care Provider Office Releasing Records):

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Date of Services: _____ to _____

To (Name of Requesting Party):

Name: **PELICAN PRIMARY CARE**

Address: **23421 WALDEN CENTER DR STE 100, BONITA SPRINGS, FL 34134**

Fax #: **(239) 593-0067** Phone #: **(239) 514-2008** Email: **info@pelicanprimarycare.com**

PURPOSE OF RELEASE OF MEDICAL RECORDS:

- ☐ Change in family doctor
- ☐ Insurance claim processing
- ☐ Legal claim processing
- ☐ Specialty appointment
- ☐ Other (specify): _____

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

Patient Signature: _____ **Date:** _____