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 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):

☐ Richichi Family Health
1217 Piper Blvd Ste 101
Naples, FL 34110
PH: (239) 514-2005
Fax: (239) 593-0067
info@richichihealth.com

☐ **PELICAN** PRIMARY **CARE**
23421 Walden Center Dr Ste 100
Bonita Springs, FL 34134
PH: (239) 514-2008
Fax: (239) 593-0067
info@pelicanprimarycare.com

Our providers: Joseph Richichi MD
Erik Huffman PA-C

## PURPOSE OF RELEASE OF MEDICAL RECORDS:

☐ Change in family doctor

☐ Insurance claim processing

☐ Legal claim processing

☐ Specialty appointment

☐ 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:** ____________________