

RANDALL HUMPHREYS, M.D.
2401 St. Andrews Blvd. Panama City, FL 32405
phone (850)785-2717, fax (850)785-2301

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient:

Name

Address

City, State, Zip

Date of Birth

Release Medical Information to:

Name **RANDALL F. HUMPHREYS MD**

Address **2401 ST ANDREWS BLVD**

PANAMA CITY FL 32405

City, State, Zip

Purpose of the Disclosure:

____ Further Medical Care
____ Legal Investigation or Action
____ Changing Physicians

Patient Rights with Respect to this Authorization:

- I. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the business office of Dr. Humphreys' office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on: _____

If I fail to specify an expiration date, this authorization will expire in two (2) years from the date signed

MHS	Retain 6 years
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Signature of Patient or Legal Representative

Date

Signature of Witness

Date

Authorizes:

Name

Address

City, State, Zip

Information to be released:

dates from _____ to _____
____ Medical History
____ Examinations
____ Reports
____ Treatment or Tests
____ Allergy Records
____ Consultations
____ X-ray Reports
____ Entire Record
____ Other _____