

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:

Authorizes:

Name

Name **RANDALL F. HUMPHREYS MD**

Address

2401 ST ANDREWS BLVD

Address **PANAMA CITY FL 32405**

City, State, Zip

City, State, Zip

Date of Birth

Information to be released:

dates from _____ to _____

Release Medical Information to:

_____ Medical History

_____ Examinations

Name

_____ Reports

Address

_____ Treatment or Tests

City, State, Zip

_____ Allergy Records

_____ Consultations

_____ X-ray Reports

_____ Entire Record

_____ Other _____

Purpose of the Disclosure:

- _____ Further Medical Care
- _____ Legal Investigation or Action
- _____ Changing Physicians

Patient Rights with Respect to this Authorization:

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