PALM BEACH
THYROID &
ENDOCRINOLOGY WELLNESS, LLC

MEDICAL RECORD RELEASE

CONSENT TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I, _____(full name), do hereby consent and authorize Palm Beach Thyroid and Endocrinology Wellness, LLC to OBTAIN/RELEASE records from/to:

Doctor name/Practice: _____ Phone: _____
Address: _____ City: _____ State: _____

☐ I authorize **ALL** records to be sent to/from PBTEW
☐ I **only authorize** the following records to be sent to/from PBTEW: _____

_____

☐ The duration of this authorization is until: _____ (date)

☐ This authorization is valid for life
Patient Signature: _____ DOB: _____ Date: _____

I understand that I may refuse to sign this authorization and may revoke it at any time in writing, but if I do it will not have any effect on any actions taken prior to receiving the revocation. I acknowledge that I have received a copy of the PBTEW Notice of Privacy Practices.
Notice to recipient of information: This information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for this release of medical or other information is not sufficient for this purpose. This information is also protected by Florida State Statute. As per Florida State Statute, this information shall be held confidential and may not be further disclosed without the informed consent of the person to whom it pertains.

PLEASE FAX RECORDS TO: 561-303-2801
ATTENTION: MEDICAL RECORDS
12957 Palms West Drive Suite 204
Loxahatchee, FL 33470