NONA MEDICAL ARTS

Multidisciplinary Pain Management & Regenerative Medicine

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Phone #: _____ SS#: _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by initialing this form, I am specifically authorizing the release of this information. _____

Initial

By signing this form, I authorize you, _____ (Physician Name or Clinic Name) Phone #: _____ Fax: _____to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Release my protected health information to the following person(s) entity:

Name: **Richard Gayles, MD (Nona Medical Arts)**

Street: **9145 Narcoossee Road, Suite A200**
City: **Orlando** State: **Florida** Zip: **32827**
Phone #: **407-412-5030** Fax #: **407-601-7946**

I **DO** give permission for these records to be faxed to the above entity.

The reasons or purposes for this release of information are as follows:
Office notes, MRI, CT, and/or actual X-Ray films, Procedure notes.

_____

_____ _____

Patient Signature (or legal representative) Date