Richichi Family Health
1217 Piper Blvd, Suite 101
Naples, FL 34110
Ph: (239) 514-2005 · Fax: (239) 593-0067
www.RichichiHealth.com

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Name: (Last, First, MI) ____________________

Address: ____________________

Phone: __________ Date of Birth: __________ SS#: __________

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital or other Health Care Provider) to release medical records:

From (Name of Party Releasing Records):

Name: ____________________

Address: ____________________

Phone #: __________ Fax #: __________

Date of Services: __________ to __________

To (Name of Requesting Party):

Name: **RICHICHI FAMILY HEALTH**

Address: **1217 PIPER BLVD, SUITE 101, NAPLES, FL 34110**

Fax #: **(239) 593-0067** Phone #: **(239) 514-2005** Email: **info@richichihealth.com**

PURPOSE OF RELEASE OF MEDICAL RECORDS:

- ☐ Change in family doctor
- ☐ Insurance claim processing
- ☐ Legal claim processing
- ☐ Specialty appointment
- ☐ Other (specify): __________

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ **Mental Health Treatment** ☐ **Sexually Transmitted Diseases** ☐ **AIDS/HIV Treatment** ☐ **Alcohol/Drug Abuse Treatment**

The Undersigned Hereby Releases RICHICHI FAMILY HEALTH from Any and All Legal Responsibility or Liability that could occur from this Action.

Patient Signature: ____________________ **Date:** __________