



Dr. James P. Muir

Authorization for Transfer of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Social Security Number
Address	City	Zip	Phone
RELEASE FROM: [Name of physician or facility releasing information]			
I authorize release of my medical record from			
Physician/Facility			
Address	City	Zip	Phone
RELEASE TO: [Name of physician or facility receiving information]			
Please send my medical record to:			
Physician/Facility			
Address	City	Zip	Phone
RELEASE INFORMATION			
Reason: <input type="checkbox"/> Change of insurance		<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Personal file
<input type="checkbox"/> Moving out of area		<input type="checkbox"/> Specialist consultation	<input type="checkbox"/> Legal

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to previous medical conditions, physical abuse, or drug and alcohol abuse. The fee for records transfer is \$25 per patient.

By signing below I am agreeing to pay the \$25 fee

YES NO Initials

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.

Citrus Park Dental, James P. Muir D.D. S., P.L.
 7620 Gunn Hwy #180 Tampa, Fl 33625
 (813)926-6776 fax (813)926-2238
 – office@citrusparkdental.com