**RELEASE OF MEDICAL RECORD**

I hereby authorize the release of any and all of my medical records as indicated below to:

Better Health Medical Center
28960 U.S. Hwy 19 N, Suite 115
Clearwater, FL 33761

Phone: (727) 771-8282
Fax: (727) 771-8788

_____ _____ ___/___/___
Patient's Name (please print) Social Security # Date of Birth

_____ ___/___/___
Signature of Patient or Legal Guardian Today's Date

____Immunization records
____Newborn Initial and Discharge Exam
____Discharge summary
____Lab reports
____EKG/Echo
____Operative Reports
____Emergency Room Records

____Pathology Reports
____Progress Notes
____X-Ray Reports
____Dr.s Orders
____Newborn Screening
____Consult Reports
____Other_____

____STAT _____Non-Stat

Patient has appointment on:_____

Confidential- For professional use only

Note: This report is strictly confidential and is for the information only of the person to whom it is addressed. No responsibility can be accepted of it is made available to any other person, INCLUDING THE PATIENT.