RANDALL HUMPHREYS, M.D.
2401 St. Andrews Blvd. Panama City, FL 32405
phone (850)785-2717, fax (850)785-2301

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient:

_____
Name

_____
Address

_____
City, State, Zip

_____
Date of Birth

Release Medical Information to:

_____ RANDALL F. HUMPHREYS MD
Name 2401 ST ANDREWS BLVD
_____ PANAMA CITY FL 32405
Address

_____
City, State, Zip

Purpose of the Disclosure:

_____ Further Medical Care
_____ Legal Investigation or Action
_____ Changing Physicians

Authorizes:

_____
Name

_____
Address

_____
City, State, Zip

Information to be released:

dates from_____ to _____

_____ Medical History
_____ Examinations
_____ Reports
_____ Treatment or Tests
_____ Allergy Records
_____ Consultations
_____ X-ray Reports
_____ Entire Record
_____ Other _____

Patient Rights with Respect to this Authorization:

I. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the business office of Dr. Humphreys' office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on: _____

If I fail to specify an expiration date, this authorization will expire in two (2) years from the date signed

MHS	Retain 6 years

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date