4611 Okeechobee Blvd. Suite 110, West Palm Beach, FL 33417
Phone: (561) 408-9444 Fax: (561) 689-7500

REQUEST FOR MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____

Please check one:

_____ ☐ Please obtain my medical records from provider/facility listed below

_____ ☐ Please transfer/send my medical records from BMHC to the provider/facility listed below

_____ ☐ I do not wish for my medical records to be released to BMHC

_____ ☐ I do not have any previous medical records for BMHC to obtain

Physician/Facility:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand that documentation released to BMHC may, unless expressively limited by me in writing, disclose sensitive information such as information relating to AIDS/HIV/STDs, drugs/alcohol abuse and/or mental/behavioral health or psychiatric care. Furthermore, I understand my medical information is being made to share amongst my health care providers to ensure optimal quality of care. I understand this information is voluntary and I may revoke this authorization in writing to BMHC at any time.

Patient Signature:_____ Date:_____