SUNCOAST CANCER INSTITUTE
THE POWER TO CARE

RECORDS REQUEST RELEASE FORM

☐I hereby authorize and request the unconditional release of my medical records ***to***:

Suncoast Cancer Institute, 1217 East Ave S. Suite 201, Sarasota, Florida 34239

 **Phone 941-200-1125** 

Fax 941-200-1126

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☐I hereby authorize and request the unconditional release of my medical records ***from***:

Suncoast Cancer Institute, 1217 East Ave S. Suite 201, Sarasota, Florida 34239

To:_____

Phone:_____ Fax:_____

I understand that my records may contain information regarding drug, alcohol, psychological, or psychiatric conditions and communicable diseases, which are protected by federal law and cannot be disclosed without written consent, unless otherwise approved in the federal regulations. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically as described below. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand.

_____ _____ _____

Last Name (printed) First (printed) Middle Initial

Birthdate: ____/____/_____ Social Security Number: _____-_____-_____

_____Date: _____

Patient's Signature (guardian/surrogate):

Physician Requesting Information: Penny Heinrich, MD
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