Dr. John Madlener, M.D.
Dr. Richard Helton, D.C.
1715 Berglund Ln, #104
Viera, FL 32940
P: 321-751-5351 F: 321-751-5370

RELEASE OF MEDICAL RECORDS FROM OTHER FACILITES

This section is for office use only:

I request and authorize:_____

to release healthcare information to:

Brevard Therapy & Physical Medicine, Dr. Madlener, and/or Dr. Helton.

This request and authorization applies to:

Full medical records held by this office: _____

A specific portion/section of the record: _____

Radiology Reports: _____

Medical record for the period: _____to_____

Other diagnostic studies: _____

Purpose of the requested disclosure: [ ] At patient's request [ ] Continuing care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon the authorization. I understand that I do not have to sign the authorization and that Brevard Therapy & Physical Medicine may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release of information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release of fax of this release shall be as valid as the original release. If I authorize Brevard Therapy & Physical Medicine to fax information, I realize there are inherent risks in faxing Protected Health Information released to anyone other than the health care provider. I understand I will get a copy of this form after I sign it if I wish to have one.

Print Name: _____ Date of Birth: _____

Patient Signature: _____Date: _____