AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

To:

Fax:

Phone:

I, ____hereby authorize the release of any and all of my medical
(Patient Name and Date of Birth)
records (including any and all HIV/AIDS records, alcohol and/or substance abuse records, and psychiatric and/or psychotherapeutic records.)

Information to be released to:

Russell W. Becker, DO, FACOS, RPVI
&
Duke M. Pfitzinger, Jr., DO, RPVI
1875 Veterans Park Dr, Suite 2203
Naples, FL 34109
Fax (239) 631-6907

I request that copies of my medical record be made and mailed or delivered in a timely manner to the above address or fax number.

I do hereby agree to hold *Vascular Center of Naples*, its agents and staff members free and harmless from any actions by it or them for alleged invasion of privacy, liable or slander, or defamation, arising in connection with the disclosure of such information.

____ ______________________

Patient or Authorized Patient Representative Signature **Date**

______________________________ ____

Printed name of patient representative **Representative's authority to sign for patient (i.e. power of attorney for healthcare)**