Beach Medical Specialist, P.A.
Alejandro C. Dizon, M.D.

9860 Beach Blvd. * Jacksom·il1e. FL 32246
Telephone#: (904) 807-9112 * Fax#: (904) 807-9114

REQUEST OF MEDICAL RECORDS

Records to be sent to the following address:
NAME: Beach Medical Specialist P.A.
( ) ADDRESS: 9860 Beach Blvd. Suite 400 Jacksonville, FL 32246
( ) ADDRESS: 161-4 Hampton Point Dr. St. Augustine, FL 32092

Records to be obtain from the following Physician/Facility:
PHYSICIAN/FACILITY: _____
ADDRESS: _____
TELEPHONE#: _____ FAX#: _____

Reason for release of records: _____

DATES OF SERVICE REQUESTED ARE: _____

I understand that the records being disclosed contain PHI. Consent is given to disclose the following: (check all that apply)

( ) Treatment Plan(s)
( ) Bio Psychosocial Assessment
( ) Hospital Notes
( ) Psychiatric evaluation(s)
( ) Physician's Progress Notes
( ) Laboratory Results
( ) HIV Test Result
( ) Sexually Transmitted Diseases
( ) Diagnostic Results (X-Ray/CT/MRI)
( ) Accounting of Disclosures
( ) Medication Record/Prescriptions
( ) Other: _____

As a part of the medical record, the following information will be release unless stricken:
SEXUAL ABUSE INFORMATION
DRUG AND ALCOHOL INFORMATION
CHILD ABUSE AND NEGLECTED INFORMATION
PSYCHIATRIC INFORMATION
AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from the date of signature.

Signed: _____ Date: _____
Patient Name/Guardian: _____ DOB: _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.