My PCP LLC
Medical Records Request or Release

Release of Records

Records to be sent to the following address:

My PCP LLC
Dr. Chloe Tochtenhagen MD
294 Paseo Reyes Drive
St Augustine FL 32095
Telephone-904-513-0113
Fax-1-904-592-5355

Reason for Release of Records: Continuity of Care

Request for Records

Records to be received from:
PHYSICIAN/FACILITY:______________________________
ADDRESS:______________________________
TELEPHONE/FAX:______________________________

Release from my medical records the following information for the following dates:
From:______________________
To:______________________

- Entire chart
- Most recent office visit______________________
- Labs______________________

Diagnostic studies______________________

As part of the medical records, the following information will be released unless stricken:

Sexual abuse information
Drug and alcohol abuse information
Child abuse and neglect information
Psychiatric information
AIDS/HIV status

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 it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant of 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 date of signature.

Signed:______________________ Date:______________
(Patient, Parent or Guardian)
Patient Name:______________________ DOB:______________
Witness:______________________ Date:______________

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