

**Genesis Medical Clinic  
11531 N 56th Street  
Temple Terrace, Florida 33617  
Phone: 813-386-0685  
Fax:813-549-7399**

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**Patient Authorization for release of protected Health Information**

To: \_\_\_\_\_  
Physician of Facility Name

\_\_\_\_\_

Street Address

\_\_\_\_\_

City/State/Zip

I hereby request that my medical records be released to

**Genesis Medical Clinic  
11531 N 56th Street  
Temple Terrace, Florida 33617**

Records requested:

\_\_\_\_\_ Complete chart including HIV results and psychiatric records  
\_\_\_\_\_ Lab reports  
\_\_\_\_\_ X-ray reports  
\_\_\_\_\_ consult reports  
\_\_\_\_\_ Medication Log  
\_\_\_\_\_ Others \_\_\_\_\_

**Please Fax medical records to: 813-549-7399**

Date of request \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Patient's DOB \_\_\_\_\_ Patient's SS# \_\_\_\_\_

Patients Signature: \_\_\_\_\_  
Witness Signature: \_\_\_\_\_