

RELEASE OF PATIENT RECORDS AUTHORIZATION

Revised: 07-2023

I hereby authorize _____ (name of person or facility) to release a copy of my patient records, x-rays or other diagnostic containing protected health information to Dynamic Care Inc. This authorization is given pursuant to Florida Statute 456057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representation.

PATIENT NAME:	
PATIENT DOB:	
DATE OF ACCIDENT (if applicable)	
LAST FOUR DIGITS OF SSN:	

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

- MAIL OR DELIVER X-RAY/ MRI/ CT STUDIES TO ADDRESS BELOW
- MAIL RECORDS TO THE ADDRESS BELOW, OR
- FAX: **407-260-1619**. (PLEASE CONTACT OUR OFFICE **FIRST** IF FAX WILL EXCEED 10 PAGES)
- EMAIL: INFO@DYNAMICCARE.NET

Patient's or Patient's Legal Representative's Signature

Date Signed

Unless revoked by me in writing, this authorization shall expire in 12 months from the date signed.

Dynamic Care Inc. 609 Maitland Ave, Suite 4 Altamonte Springs, FL 32701
Phone: 407-767-2000 Fax: 407-260-1619