

## **Suncoast Family Medical Associates** **Authorization for the Release of Information**

I hereby give my permission to (list physician/facility name and address):

\_\_\_\_\_

\_\_\_\_\_

To release a copy of my medical records to:

- Jeffrey S. Grove, D.O.
- Ty L. Tvedten, D.O.
- N. Nicholas Engelman, D.O.
- Krista M. Keith, D.O.
- R.L. DaSo, D.C.

a physician with Suncoast Family Medical Associates. Please forward records to the following location:

12020 Seminole Blvd.  
Largo, FL 33778  
(727) 588-9572  
(727) 559-7181 fax

The undersigned is a patient of Suncoast Family Medical Associates or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment, unless specified below, which may be a part of the medical records.

Print Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_