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BlueBird Care Physicians
Internal Medicine / Primary Care

Medical Records Release Form

Attention:_____

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Patient Name: _____**Date of Birth**: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility/entity listed below.

BlueBird Care Physicians
Ronald Mendez, MD
1936 Dariy Rd, West Melbourne, FL 32904
Ph: 321-821-4041 Fax: 800-521-7876

The information you may release subject to this signed release is as follows:

☐ Complete records	☐ History and Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Records	☐ Medication Records	☐ Other (Please Specify):

The purpose/reason for this release of information is as follows: ☐ **Establish care**/ ☐ **Continuity of care**

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_____ _____

Signature of Patient or Representative **Date**

_____

Description of Personal Representative's Authority