Please Send Records To:
Andrew Marlowe, M.D. – Chad Marrs, M.D.
5432 Bee Ridge Road Suite 150, Sarasota, FL 34233
Phone: 941-379- EARS (3277) Fax: 941-379-6277

Patient Name: _____ Date of Birth: _____

Requesting Records From: _____

Address: _____

Phone: _____ Fax: _____

For the following purpose: _____ Consultation _____ Continuation of Care

Include the following Records: _____ All Records _____ Office Notes

_____ Hospital Records _____ Laboratory Results

_____ Audiology Records _____ CT Scan

_____ Other: _____

The following items ***must be initialed*** to be included/ disclosed:

_____ HIV/AIDS related information _____ Psychotherapy notes _____ Mental Health records

_____ Genetic Testing records _____ Drug/ Alcohol diagnosis, treatment, or referral

Federal regulations require a description of how much and what kind of information is to be disclosed.

Description: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and may no longer be protected by these regulations. The recipient may, however, be prohibited from redisclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I, therefore, release Andrew Marlowe, M.D, P.A., it's employees, and Dr. Marlowe from all liability arising from the Authorization for disclosure of my protected health information.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so. *This item is not required if the disclosure is requested by the patient*.

I further understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits. I may inspect or copy any information to be used and/or disclosed under this Authorization. *This item is not required if the disclosure is requested by the patient*.

Finally, I understand that I may revoke this Authorization any time, provided that I do so ***in writing***, except to the extent that action has already been taken in reliance upon this Authorization. Unless revoked earlier, this Authorization will expire 180 days from the date of signing.

_____ _____

Signature of Patient or Legal Representative Date Signed

_____ _____

Print Patient Name or Legal Representative Relationship to Patient