Florida Oncology Tavares
RADIATION TREATMENT CENTER

REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

_____

_____
Name and Address of Practitioner

To be sent to:

Florida Oncology Tavares
2010 Nightingale Lane
Tavares, Florida 32778
Phone 352-742-3045 Fax 844-651-2147

	Item		Item
●	Office Visit Note	●	MRI films and reports
●	Pathology Report	●	Bone scan films and reports
●	Operative Report	●	Lab Results
●	Discharge Summaries	●	Radiation Treatment Records *All DICOM, RT Dose and RT Structure Set Files sent via Powershare to Florida Oncology Tavares*
●	CT scans and reports	●	Simulation/Port Films
Other:			

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Oncology Tavares to receive copies of any medical, psychiatric, Aids, Aids relates syndromes, HIV testing, Alcohol and/or drug abuse related information from the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire one (1) year after the date below or sooner at my election.

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature Patient, Parent or Legal Guardian/Representative Date