Regenexx® Tampa Bay

2401 University Parkway, Suite 104, Sarasota, Fl 34243 Phone: 941-357-1773 Fax: 941-256-7452
8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 Phone: 813-544-3123 Fax: 941-256-7452

To: _____
(Providing Facility / Location)

Phone Number: _____ Fax Number: _____

_____ _____/_____/_____ _____-_____-_____
Patient Name **Date of Birth** **SSN**

I Request That Records Be Released That Pertain to The Following Body Region(s):

_____

Specifically, I Request for The Following to Be Sent:

____ **X-Rays (Radiology Report and Imaging Disk)**
____ **Mri's (Radiology Report and Imaging Disk)**
____ **Consult Reports**
____ **Operative Reports**
____ **Complete Records**
____ **Other** _____

Please Release to:

___ 2401 University Parkway, Suite 104, Sarasota, FL 34243 - Phone: 941-357-1773 - **Fax: 941-256-7452**

___ 8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 - Phone: 813-544-3123 - **Fax: 941-256-7452**

Requesting Provider:

____ **James Leiber, D.O.**

____ **Michael Amoroso, M.D.**

____ **Ronald Torrance, D.O.**

____ **Ignatios Papas, D.O.**

I authorized your facility to release the medical records requested by New Regeneration Orthopedics of Florida.

_____ ___/_____/_____
Patient Signature **Date**

I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice.