HARBOR PHYSICIANS
Primary Care & Internal Medicine

2140 Kingsley Ave, Suite 1, Orange Park, FL 32073
Ph: 904-368-6809 | Fax: 904-368-6809

Medical Records Request Form

Please complete this form to authorize the request of your medical records.

Patient Information
Name: _____ DOB: _____
Phone: _____
Address: _____

Records Release (Office Use Only)
Do NOT complete provider section

Please do NOT complete the "Provider/Facility" section below. This section will be completed by our office to allow this authorization to be used for multiple providers and to ensure accurate processing of your request.

Provider/Facility: _____
Address: _____
Phone: _____ **Fax**: _____

TO BE RELEASED TO:

Provider/Facility: *Harbor Physicians* **Address**: 2140 Kingsley Ave Suite 1, Orange Park, FL 32073 **Phone**: 904-368-6809 **Fax**: 904-368-6809
Information to be Released

☐ All records ☐ Dates: _____ to _____

☐ Specific: _____

Purpose

☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other: _____

Expiration
This authorization expires 12 months from signing unless otherwise specified: _____

Authorization
I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken. Information disclosed may be subject to redisclosure.

Signature: _____ Date: _____
Representative (if applicable): _____
Relationship: _____