SUNCOAST CANCER INSTITUTE
THE POWER TO CARE

RECORDS REQUEST RELEASE FORM

Date: _____

I hereby authorize and request the unconditional release of my medical records to:

Suncoast Cancer Institute

1217 East Avenue S. Suite 201, Sarasota, Florida 34239

 **Phone 941-200-1125**  **Fax 941-200-1126**

I understand that my records may contain information regarding drug, alcohol, psychological, or psychiatric conditions and communicable diseases, which are protected by federal law and cannot be disclosed without written consent, unless otherwise approved in the federal regulations. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically as described below. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. This release will expire in one (1) year.

_____ _____ _____
Last Name (printed) First Middle Initial

Birthdate: ____/____/_____ Social Security Number: _____-_____-_____

Patient's Signature (guardian) witness: _____ Date: _____

Physician Requesting Information: Penny Heinrich, MD