6150 SW 76 St, 1st Floor
Miami, FL 33143
Tel: (786) 709-9990
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MEDICAL RECORD RELEASE FORM

Prime MD Miami

Rekha Kini, MD
Kim Bango, MD

Patient Name ____________________________________ Date of Birth ______________________

I hereby authorize the below listed entity to release medical information to **Prime MD Miami**:

Name: ____ Telephone#: ___________

Address: ______________________________________ Fax#: ______________

____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records: ____________________________________
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.} ____________________

____ ____________________

Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.