NORTH PALM FAMILY PRACTICE
DR. ARLENE TAYLOR
3385 BURNS ROAD STE. 207
PALM BEACH GARDENS, FL. 33410
TEL: 561 249-0149
FAX: 561 249-0151

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:______________________________ DOB:____________

SS#:________________
(Optional)

I Request and authorize__________________________, FAX #_____________
to release medical records of the subject patient to:

ARLENE TAYLOR D.O.
NORTH PALM FAMILY PRACTICE
3385 BURNS ROAD STE. 207
PALM BEACH GARDENS, FL. 33410
TEL: 561 249-0149
FAX: 561 249-0151

Records requested:

✓	Progress Notes
✓	Labs
✓	Consults
✓	X-rays & Scans
✓	Other- ALL

Patient Signature:__________________
Date:__________ (This Authorization Expires 90 Days after it is signed)

Confidentiality Notice: This information is intended for the use of the person or entity to which it is addressed and may contain information that is priviliged and confidential the disclosure of which is governed by applicalbe law If the reader of this message is not the intended reeipient, you are hereby notified that any dissemination, distribution or copy of this information is strictly prohibited. If you have received this message by error, please notify the above addressee and delete the related message from your files