Release of Medical Information

Requesting records from:

Name of Practice:______________________________

Name of Physician:______________________________

Fax number:______________________________

Address:______________________________

Please send records to:

Attention: James M Grimes MD Orthopaedics

At fax number: 904-217-3224

Or mail to: 52 Tuscan way, Suite 205
St. Augustine, FL 32092

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other____________________

Patient's Signature______________________________ Date __________

Authorized Representative's Signature____________________ Date__________

Relationship of Authorized Representative______________________________

Please allow for 24 - 48 Hours for the request to be completed