TEPAS™
BREAST CENTER

Release of Medical Records Request

( ) I hearby authorize:_____, to release my medical records to:

TEPAS Breast Center
1140 Broadband Drive
Melbourne, FL 32901

Office (321) 312-4178
Fax (321) 733-211

Any information including diagnostic imaging, reports, and medical records and/or examination rendered to me during the perior of _____ to _____ to include any and all Federal and State protected information including without limitation psychiatric, drug, and/or alcohol abuse and human immunodeficiency virus test results (Aids and related conditions).

I understand and direct that this authorization remains in effect for 1 year or until I revoke it in writing. I hereby release Tepas Breast Center and/or Tepas Healthcare, it's employees, vendors and independent contractors from any and all liability that may arise from the release of this information as I have directed.

_____

Signature of Authorized Personnel **Date**

I have reviewed and fully understand this document, and have no unanswered questions. I have reviewed & understand this page, and have no unanswered questions.

_____

Patient Signature **Date**

LastName
FirstName
DOB
Age
PtSex