COVENANT
METABOLIC SPECIALISTS

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Phone: 941-500-3200
855-444-9595
Fax: 941-500-4680

Patient Name: _____ **DOB**: _____

This will authorize:_____

to release/obtain general medical records in accordance with Florida's statutes and Federal Regulations (42 CFR Part 2). The release of any information concerning AIDS, HIV, ARC, and the performance of any test, counseling and the results and treatment thereof are also authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained in this authorization.

This information is to be released: ☐ TO ☐ FROM

DR. GUY NEFF

COVENANT RESEARCH

6230 UNIVERSITY PARKWAY, Suite 203
SARASOTA, FL 34240
PHONE: 941-500-3200 FAX#: 941-500-4680

❑ Release the following (most recent dates, unless otherwise requested):

For the service dates of: _____

❑ Procedures: _____ ❑ Office Notes ❑ Labs/Path/Radiology/Nuclear Med

❑ Other: _____
_____

I do not want the following health information disclosed:

_____
_____

Please fax records to 941-500-4680 Attention: _____

This transmission, including any attachments, is confidential, proprietary, and may be privileged. It is meant solely for the intended recipient. If you are not the intended recipient, you have received this transmission in error and you are hereby notified that any review, disclosure, copying, distribution, or use of this transmission or any information included therein, is unauthorized and strictly prohibited. If you have received this transmission in error, please immediately notify the sender by reply and permanently delete all copies of this transmission and any attachments.

Patient or Legal Representative: _____ Date: _____

*This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the express written consent of the person to whom such information pertains, or as otherwise permitted by state law. Information disclosed may include sensitive health conditions, which may include but may not be limited to, drug or alcohol abuse, behavior health care/mental health services, sexually transmitted diseases, birth control and genetic diseases or tests, HIV, AIDS and other conditions. This authorization is for a continuing disclosure, valid for five (5) years after the date of my signature. In the event these records are being requested other than for the personal use of the patient or an attending physician, fees may apply in accordance with Florida State Statute 395.3025.