PRECISION
Health Primary Care

When it comes to your health, choose Precision.

Shaival Thakore, M.D.
14100 Fivay Road, Suite 100
Hudson, FL 34667
Phone 727-819-2534
Fax 727-819-2687

Records Release Authorization

Complete this form only if you want us to request your records from a previous doctor. Use a separate copy for each office, and bring it with your New Patient Paperwork.

Patient name _____ Date of birth _____

RELEASE RECORDS FROM

Doctor or office _____ Phone _____ Fax _____

Address _____

RECORDS TO RELEASE

☐ Complete medical record ☐ Office notes ☐ Lab results ☐ Imaging reports

☐ Immunization records ☐ Medication list ☐ Other _____

Dates of service from _____ to _____

I specifically authorize release of the following, if present in my records:

☐ HIV/AIDS test results ☐ Mental health records ☐ Substance use treatment records

RELEASE RECORDS TO

Precision Health Primary Care, Dr. Shaival Thakore, 14100 Fivay Road, Suite 100, Hudson, FL 34667. Phone: 727-819-2534. Fax: 727-819-2687.

Purpose: ☐ Continuity of care ☐ Other _____

TERMS

- This authorization expires one year from the date signed unless I revoke it sooner.
- I may revoke this authorization at any time by writing to the provider releasing my records, except to the extent action has already been taken on it.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information released under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy rules.

Signature of patient or authorized person (sign by hand) _____ Printed name _____ Date _____

If signing for the patient, your relationship and authority: _____