

Creation's Own Corp.[®]

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REQUEST FOR RELEASE OF MEDICAL RECORDS TO CREATION'S OWN

Note: This form must be fully filled out prior to signing. An incomplete form will not be honored.

Patient's Name _____ DOB: _____
(Please print)

I hereby authorize the use and disclosure of my minor child's (or my own) individually identifiable health information and records as described below.

Please check the box that applies to your request:

- Immunization Record ONLY
- Lab reports from the last 6 months, ONLY
- Complete medical record (Notes and lab reports)
- Medical records (Notes and lab reports) from _____ to _____
- All lab reports
- Only lab reports from _____ to _____
- Other _____

Release records from:
(Please Print)

Name

Address

City State Zip

Send records to (**Do not fax records or send electronically**):

Creation's Own Corp.[®]
 ATTN: Patient Records
 3800 W. Eau Gallie Blvd., Suite 105
 Melbourne, FL 32934

 Patient Signature / Parent or Guardian (if patient is a minor) Date _____

Relationship to patient:

- Mother
- Father
- Legal Guardian
- Patient

Florida
 3800 W. Eau Gallie Blvd., Suite 105
 Melbourne, FL 32934
 321.259.7111 • Fax 321.259.7222

California
 California Integrative Hyperbaric Center
 16251 Laguna Canyon Rd., Suite 175
 Irvine, CA 92618

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