# *Center for Health*

## *David E. Ruggieri, M.D.*

Cardiology and Internal Medicine

Medical Records Release/Receipt

I hereby authorize

______________________________________________

to release information including, if any, psychiatric or psychological information, infections, or contagious disease information (including HIV/AIDS confidential information) and/or information about drug or alcohol abuse or treatment from the health record (s) of:

Patient Name

___________________________________________________

SSN __________ - ______ - __________ Date of Birth ________________

Patient Address

_________________________________________________

Covering the period (s) of treatment from ________________ to _____________

Information to be released ________________ Complete______
Other_______

Information to be released to: David E. Ruggieri, M.D.
713 E. Marion Ave., 4th Floor
Punta Gorda, FL 33950
(941) 637-7000 Fax – (941) 639-7576

Purpose of Disclosure

____________________________________________

I hereby release

______________________________________________________

And affiliates from any liability, responsibility, claims and damages which may result from the release of information authorized by this Consent for Release of Medical Information.

I have read and understand the Consent for Release of Medical Information and have voluntarily and knowingly signed such consent.

___________________________________________________ ________________

Patient Signature Date

___________________________________________________ ________________

Witness Date


713 East Marion Avenue, 4th Floor (941) 637-7000

Punta Gorda, FL 33950 Fax (941) 639-7576

15121 Tamiami Trail

North Port, FL 34287