



Request To Release Medical Records to:
New reGeneration Orthopedics Of Florida, LLC
2401 University Parkway Suite 104 | Sarasota, FL 34243
Phone: 941-357-1773 Fax: 941-256-7452

I Will Complete A Records Release Form For Each Facility Whom I Ask To Have Records Sent To Dr. Leiber, Dr. Amoroso, and/or Dr. Torrance

I Request For My Medical Records To Be Released From:

Physician/Clinic Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

I Request That Records Be Released That Pertain To The Following Body

Region(S): _____

Specifically, I Request For The Following To Be Sent:

- X-Rays (Radiology Report And Imaging Disc) Operative Reports
- Mri's (Radiology Report And Imaging Disc) Lab Tests
- Consult Reports Complete Records

Release To:

New Regeneration Orthopedics Of Florida, LLC

James Leiber, D.O. Michael Amoroso, M.D. Ronald Torrance, D.O.

Affiliate Network Providers For Regenexx

2401 University Pkwy Ste 104 | Sarasota, FL 34243

Phone: (941)357-1773 Fax: (941) 256-7452

For The Purpose Of Continuity Of Care

Patient's Name

_____-_____-_____
Date Of Birth

_____-_____-_____
Social Security #

Patient Signature

_____-_____-_____
Date

I Understand That The Information In My Health Record May Include Information Relating To Sexually Transmitted Disease, Aquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (Hiv). It May Also Include Information About Behavioral Or Mental Health Services, And Treatment For Alcohol And Drug Abuse Or Self-Paid Services. You Are Hereby Specifically Authorized To Release All Information Or Medical Records Relating To Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year From The Date Of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization At Anytime Upon Request. The Disclosed Information May No Longer Be Protected By The Privacy Practices Of This Practice.