



MEDICAL RECORDS RELEASE FORM

**To request the release of medical information, please complete
and sign this form and fax it to 561-363-5450.**

☐ Release my protected health information to me.

Or

☐ Release my protected health information to,

Name: _____

Fax: _____ Phone: _____

Email: _____

If you would like the records mailed, provide the address below.

Address: _____
Street City State Zip

Reason for release: _____

Restrictions (if any): _____

I hereby authorize Andrologix Health and Wellness LLC. and parent company Sozo Group, LLC. (Company), to release my medical information as requested above. This authorization will remain active for one year from date of signature, unless revoked in writing. I am aware that the Company cannot control how the recipient uses the information, and that laws protecting its confidentiality at the Company may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

Print Your Name

Your Signature

Date