Authorization for the Release of Medical Records

Date: _____

Patient Name: _____

Date of Birth: _____ SS#:_____Phone #: _____

Patient Address: _____

_____

I authorize _____ to release medical information from my medical records to:

596 Ocoee Commerce Parkway
Ocoee, FL 34761-4219
(407) 654-3505
(407) 654-4956

SPECIFIC DOCUMENTS TO BE RELEASED:

( ) ALL Records ( ) X-Ray Films ( ) Discharge Summary
( ) Operative Reports ( ) History & Physical ( ) AIDS/ HIV
( ) Psychiatric ( ) Drug/ Alcohol ( ) Other: _____

( ) Lab/ Radiology Reports ( ) Progress Notes

( ) Specific Date (s) of service: _____

( ) Hand Carry ( ) Mail

PURPOSE FOR INFORMATION:

( ) Continued Medical Care ( ) Second Opinion ( ) Insurance

This request is authorized to include any federal and/ or state protection under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and/ or 397.50(3) records of minor client.

NOTE TO REQUESTING PARTY: Florida statue has established guidelines and cost rates for the copying of records. Your signature on this form indicates your knowledge of this statement.

I hereby release _____, and its employees, agents, officers and affiliates, from any and all liability, responsibility, claim and damages which may result from the release of information authorized by the consent for release of information.

SIGNED: _____Date: _____
(If not patient, state relationship-Must provide Power of Attorney and/or Legal Guardianship)

Form of ID verified: _____

Witness: _____ Date: _____