

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

SPECIFIC DOCUMENTS TO BE RELEASED:

- | | | |
|--|---|--|
| <input type="checkbox"/> ALL Records | <input type="checkbox"/> X-Ray Films | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> History & Physical | <input type="checkbox"/> AIDS/ HIV |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Drug/ Alcohol | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lab/ Radiology Reports | <input type="checkbox"/> Progress Notes | |
| <input type="checkbox"/> Specific Date (s) of service: _____ | | |
| <input type="checkbox"/> Hand Carry | <input type="checkbox"/> 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 statute 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: _____