**AUTHORIZATION TO RELEASE MEDICAL RECORDS TO OUR PRACTICE**

**PLEASE PRINT CLEARLY AND FILL IN ALL BLANKS. THANK YOU!!**

Patient Name: ________________________________ ____________________________ ______
Last First M.I.

Address: ____________________________________________________________________
Street City Zip Code

Home Phone: ______________ Cell Phone: _______________ Work Phone: ____________

Social Security # _____________________ Date of Birth: ___________________________

## I AUTHORIZE: **We MUST have complete address OR phone number**

Physician / Hospital / Facility: __________________________________________________

Street Address: _______________________________________________________________

Phone # ________________________________ Fax # _______________________________

## TO RELEASE INFORMATION TO:

WINTER PARK FAMILY HEALTH CENTER
Dr. Rahn Shaw/ Dr. Ronald Stanish / Kelly O' Sullivan Stobbe PA-C, MS
2950 Aloma Avenue Suite 100
Winter Park, Fl 32792
Phone (407) 679-9222 Fax (407) 679-9061

Information available for release is listed below. Please indicate authorization for release the category of the information you wish to be released.

Hospital Care Summary______ Diagnostic Test/ Labs ________ HIV Treatment ______
Drug/ Alcohol Treatment__________ History and Physical ___________
Psychiatric / Psychological ________Complete Medical Records _______ Other_______

I understand a reasonable fee may be charged for copying my medical records.

I understand this consent can be cancelled at any time with written notice. A written notice will have no effect in the future of any records that may have been released prior to the receipt of the written notice. This authorization will remain in effect for no longer 90 days in order to complete the transfer of medical records. Requesting party agrees to hold releasing party harmless for any damages suffered by the requesting party for information released to third parties in good faith. To the party receiving this, the information disclosed is confidential. Any further disclosure is strictly prohibited without written permission form the patient.

Patient Signature: _________________________________ Date: _____________________
If legal guardian, state relationship: _____________________________________________
Witness Signature: ________________________________ Date: ______________________