

ALAFAYA WOODS FAMILY MEDICAL CENTER, P.A.

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Medical Records Release

RELEASE TO	
Patient Name:	DOB:
Soc Sec (last 4 digits)	Phone:
I hereby authorize and request that you release the medical inf	formation chosen below to:
Provider, facility or hospital	
Information requested (check all that apply)	
Complete Medical Chart (last 3 years)Lab resu	iltsImaging results
Office visit notes other	
I understand that my consent is required to release any health diagnosis and/or treatment for HIV (AIDS virus), sexually transformental health or drug and/or alcohol use. If I have been tested transmitted diseases, psychiatric disorders or mental health or specifically authorized to release all health information pertain treatment. As required by state and federal law, Alafaya Woods disclose your health information, except as provided in our Not authorization. Your signature on this form indicates that you are disclosures of the protected health information described on the	nitted diseases, psychiatric disorders or , diagnosed or treated for HIV, sexually drug and/or alcohol use, you are ing to such tests results, diagnosis and Family Medical Center, PA may not use tice of Privacy Practices, without your e giving permission for the uses and
TO OBTAIN	
hereby Authorize:	to release my health information as
chosen above to Alafaya Woods Family Medical Center, PA.	
Patient Name:	DOB:
Patients Signature:	Date:
Signature of Parent/Guardian/Legal Representative	

or