



**Medical Record Release Authorization**

To: \_\_\_\_\_

Source/Doctor/Hospital: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

I hereby authorize the above identified source to release medical information and records to Mid-Florida Primary Care, its physician, members/or employees, including all medical records or other information regarding my treatments, hospitalization, and/or outpatient care for my illness/impairment(s), including psychological or psychiatric impairments(s), drug abuse or drug related problems, and/or alcohol abuse, and/or HIV (including AIDS), or tests for HIV, and or sexually transmitted diseases, and/or information about how my impairment(s) affect(s) my ability to complete tasks and activities of daily living or my ability to work.

- Last 3 visit notes
- Labs
- Diagnostics
- Consultations

This authorization is effective until \_\_\_\_\_ and may be revoked at any time.

I understand that the release of transfer of the information specified to any person or entity not specified above is prohibited. I understand that records pertaining to me in your possession may contain information from health care provider as well as administrative and/or insurance data, which is not strictly medical in nature. An additional written consent must be completed for any proposed new use of the information or for its transfer to another person or entity.

I release and hold harmless Mid Florida Primary Care., and the physician’s medical practice, corporation, associate, members, and employees, for all liability, including for negligence that may arise from complying with this authorization.

Purpose of the authorization: 1  continuing medical care, 2,  Personal use, 3  Insurance Co. 4.  Attorney, 5.  Other – specify \_\_\_\_\_

**I acknowledge that I have read and fully understand this authorization as it applies to me:**

Patient’s Sign: \_\_\_\_\_ SSN \_\_\_\_\_ Date of request \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Legal guardian if minor)

Print Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Name \_\_\_\_\_ Sign \_\_\_\_\_

MG/lc  
03/10/09

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