



Phone: 407-688-9446 or Fax: 407-688-9448

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I _____, Name of Patient/Guardian Name of Patient
 Date of Birth _____ Social Security Number _____ give authorization
 for Florida Arthritis Center, PL to release to/ or obtain my protected health information/ medical records from the following
 Physician and/ or Facility.

(Name/ Physician/ Facility/ Agency/ Organization)

(Complete Address)

(Phone Number/ Fax Number) THE PURPOSE OF THE USE OR DISCLOSURE IS (Please check (✓) all that apply):		
Continued Patient Care	Attorney/ Legal	Social Services/ Disability
Insurance	Personal Use	Patient Transferring PCP
Patient Moving	Other:	Other:

Please ONLY send the following records: OFFICE NOTES, PROBLEM LIST, PERTINENT LABS, IMAGING & DIAGNOSTICS REPORTS I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials or check (✓) mark on the lines below authorize the release (if applicable) of information pertaining to:
 Alcoholism and/ or Drug abuse* Mental health and/ or rehabilitation* HIV/ AIDS/ Sexually Transmitted disease & testing for other communicable diseases

I understand that this information will be used solely for professional purposes, will remain confidential and may not be disclosed to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance there on. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original. In consideration of this consent, I hereby release the above parties from any and all liability arising the reform.

Print Patient Name _____

Signature of Patient/ Guardian _____

Dated _____