# 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:**

PARK AVENUE MEDICAL
DR. Rahn Shaw / Dr. Roberto Perez / Kelly O'Sullivan-Stobbe PA-C, MS
202 North Park Avenue
Apopka, Florida 32703
Phone (407) 889-4711 Fax (407) 889-7742

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 & 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 than 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 from the patient.

Patient Signature: ___________________________ Date: _______________________________
If legal guardian, state relationship: _________________________________________________
Witness Signature: _______________________________________ Date: ___________________