Johnson Riverside Family Practice

Authorization to Release Medical Records

Name of patient _____ Date of service from_____ to _____

Date of Birth_____ Social Security number _____

I, the undersigned, authorize the release of the information specified below from the medical record (s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

- Continuing medical care

INFORMATION TO BE RELEASED

- History and physical____ Lab/Path Reports____ Operative Reports____
- Consultation Report____ Discharge Summary____ X-Ray Reports/Images____
- Emergency Room Records____ Other____

The above information may be released to,

TO:

Johnson Riverside Family Practice Phone 863-946-0284

43 Ave J SW Moore Haven, Fl 33471 Fax 863-946-0794

FROM:

I understand that my records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specific information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and Aids.

I understand that I may revoke this authorization in writing at any time except to the extent that the action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

DATE:_____ Signature_____

Print name of patient or Legally authorized Representative

_____

Relationship to patient_____