

WOODSTOCK MEDICINAL DOCTORS OF FLORIDA

6650 Indiantown drive suite 200
Jupiter, florida 33458
Phone: 561-227-9163
Fax: 352-678-3430

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ SS# _____ DOB _____
(Please Print)

HEREBY AUTHORIZE WOODSTOCK MEDICINAL DOCTORS OF
FLORIDA TO:

OBTAIN _____ RELEASE _____

Doctor/Facility

PHONE#

FAX NUMBER

_____/_____

THE PATIENT RECORDS IN YOUR POSSESSION:

~LABORATORY STUDIES _____ ~DIAGNOSTIC/TESTING _____
~OTHER _____

CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD
FROM _____ TO _____

THE PURPOSE OF REQUEST (PLEASE MARK)

CONCURRENT CARE _____ MOVING _____ TRANSFERRING _____ SELF _____ INSURANCE _____

I specifically consent to the release of any material in your possession, including, if any, existing results of HIV (AIDS) test and any which might address chemical dependence, depression, or other psycho emotional issues. I understand that I do have the right to limit the release of this information at anytime by putting my request in writing.

I request the provider named above promptly honor this request for medical information and/or copies of medical records. A copy of this request is as valid as the original. This authorization and request is valid for a period of one year from the date signed below, unless I request in writing to have this authorization revoked. I do, however, understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I may inspect and obtain a copy of any information disclosed.

PATIENT SIGNATURE(X) _____ DATE _____

Address _____ City _____ Zip _____ Telephone Number _____

Faxed by: _____ Date _____