WOODSTOCK MEDICINAL DOCTORS OF FLORIDA

6735 conroy winderemere road suite 312
Orlando, florida 32835
Phone: 407-965-5967
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 POSSESION:

~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_____