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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize and request release of the following:
_____History and management summary notes including laboratory results, and imaging.

RELEASE MEDICAL RECORDS TO:
Name of facility/person
to receive information:____

Address: ____

City, State, Zip: ____

TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Redisclosure is prohibited without the written permission of the patient/client/legal representative listed above.

TO REQUESTING PARTY: I understand signing this document releases Central Florida Endocrine & Diabetes Consultants, P.A. from all legal responsibility and/or liability arising from the release of such records. Florida Statue has established guidelines and cost rates for copying of medical records. Your signature indicates your knowledge of this statement.

NOTE: PATIENT/REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE:

Psychiatric/psychological information ___________(initials)
Alcohol/drug/chemical information ___________(initials)
HIV tests and information pertaining to tests/treatment ___________(initials)

Patient's Name (printed):____Date:_____________

Address:_______________________________________ Date of Birth____________

Witness:____Date:____________________