UNIVERSITY FAMILY MEDICINE CENTER, PA
10055 University Blvd. Orlando, FL 32817
Phone: (407) 679-4800 Fax: (407) 679-0574

Authorization For Release of Medical Records

Patient's Name:_____ **Date of Birth:**_____
Address:_____
Phone:_____ **Email:**_____

I give authorization for University Family Medicine Center, PA to: **Discuss/Release** my records to
Name: _____ Phone:_____
Address: _____ Fax:_____

I hereby authorize University Family Medicine Center, P.A. to: **Obtain** my records from

Name:_____
Phone:_____ Fax: _____
Address:_____

Records to be released:
( ) The past twelve (12) months.
( ) From the time period from_____ to _____.
( ) Specifically release only the following: _____
_____

I authorize to release copies of all medical records of my treatment including any medical, psychiatric, mental health, HIV/AIDS, alcohol and/ or drug abuse, eating disorders, and any other medical information of a sensitive nature.

Withhold from release: (Please specify if any) _____.

I understand that this authorization may be revoked upon written notice to University Family Medicine Center, P.A. except to the extent that action has already been taken on this authorization and prior to my revocation. This authorization shall remain valid for one year or on the following condition:_____.
I understand that there may be a charge for copying my records as provided under federal and state law.

_____ _____ _____
Signature (patient, parent, or guardian) **Date** **Print Name**

_____ _____ _____
Witness Signature **Date** **Print Name**

Please note that this request cannot be processed unless witnessed