

Family Medical Center
2863 S. Delaney Ave.,
Orlando, FL 32806
Phone: 407-843-1620 | Fax:
407-843-5243



Medical Records Release Form

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ / ____ / ____

Address: _____

City: _____ State: ____ Zip: _____

Phone Number: _____

AUTHORIZATION REQUEST

RELEASE INFORMATION FROM WHAT FACILITY:

Provider/Organization: _____

Address: _____

Phone: _____ Fax: _____

RELEASE INFORMATION TO WHAT FACILITY/PERSONS:

Provider/Organization: _____

Address: _____

Phone: _____ Fax: _____

PURPOSE OF DISCLOSURE

☐ Medical Care ☐ Insurance/Benefits Eligibility ☐ Immunization Records

☐ Other: _____

INFORMATION TO BE RELEASED

☐ Complete Health Record ☐ Visit Summary ☐ Clinical Documentation

☐ Consultation Reports ☐ Immunization Records

☐ Progress Notes ☐ Radiology Reports

☐ Pathology Reports ☐ Laboratory Results

☐ Photographs/Videos ☐ Other: _____

DATES OF SERVICE REQUESTED

From: ____ / ____ / ____ To: ____ / ____ / ____

SENSITIVE HEALTH INFORMATION IF APPLICABLE

☐ HIV/AIDS ☐ Behavioral Health ☐ Substance Abuse

☐ STD Information ☐ Genetic Testing

☐ Other: _____

PATIENT RIGHTS & ACKNOWLEDGEMENTS

I may revoke this authorization at any time by providing written notice, except to the extent action has already been taken. Information disclosed may be subject to re-disclosure by the recipient. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon signing this authorization. This authorization expires ninety (90) days from the date signed unless otherwise specified.

Alternative Expiration Date/Event: _____

SIGNATURE AUTHORIZATION

Patient Signature: _____ Date: ____ / ____ / ____

IF NOT THE PATIENT PLEASE SIGN BELOW

Representative Name: _____

Relationship to Patient: _____

Representative Signature: _____

OFFICE USE ONLY

Date Request Received: _____

Processed By: _____

Date Completed: _____

