Port St Lucie, FL 34986
(772) 212-7636
Fax: (772) 212-7625

Authorization to Release Medical Information / Records

PLEASE PRINT CLEARLY

Patient name _____
Last First Initial

Date of Birth _____Social Security #_____Phone #_____

Release records FROM:

_____
Releasing Doctor

Address _____
Street

_____Phone_____
City Zip

Release records TO:

_____
Recipient Doctor

Address _____
Street

_____Phone_____
City Zip

Specify Records Requested: _____

Release records Via: *MINIMUM OF 1-2 DAYS FROM DATE OF REQUEST*

MAIL TO (Name / Address): _____

FAX TO (Name / Fax #): _____

PICK UP (Phone number to call when records are ready for pick up): _____

_____ I consent to release information regarding **Substance Abuse**
(initials)

_____ I consent to release information regarding **Mental Health**
(initials)

_____ I consent to release information regarding **HIV / AIDS**
(initials)

I understand that I may revoke this consent any time prior to the actual sending of the medical information.

_____ _____
Patient or Legal Representative Signature **Date**