NORTH FLORIDA
INTEGRATIVE MEDICINE

Release of Medical Records

Patient Name: _____

Date: _____

I hereby authorize _____ to release my medical

records for the specific dates of _____ to _____.

_____ This consent includes authorization for documents that may contain information concerning HIV, Drug and/or Alcohol, STDs, or Psychiatric Care.

Patient Signature: _____

Legal Guardian (*if minor*): _____

Witness: _____

Receive medical records from: _____

Send medical records to:

NORTH FLORIDA INTEGRATIVE MEDICINE

915 W. Monroe St. Suite 301

Jacksonville, FL 32204

PHONE: 904.353.8562 **FAX:** 904.353.8607

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