elevate
HEALTH | GYN | MED SPA

3190 Citrus Tower Blvd., Suite B, Clermont, FL 34711
305 S. Childs Street; Leesburg, Fl 34748

Medical Records Release

Patient Name: _____ Date of Birth: _____/_____/_____

Social Security #: XXX-XX-_____ Phone: (_____) _____-_____ Home Cell

I authorize: _____
(Doctor or Facility we are receiving records from)

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

To release the following information:

All Records	Lab/pathology records	X-rays / radiology reports
Billing Records	Abstract / Summary	Pharmacy / prescriptions records

Other:_____
_____

To the following medical facility:

Elevate Health, Medspa & Gyn
3190 Citrus Tower Blvd., Suite B, Clermont, FL 34711
305 S. Childs Street; Leesburg, Fl 34748
Phone: (352) 432-1414 - Fax: (352) 432-1479

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164 524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the Federal confidentiality rules. Any re-disclosure of this information by the recipient is not protected under this authorization. This authorization shall remain valid for six (6) months from the date signed below.

Signed: _____ Date: _____
Patient or Authorized Person Parent Legal Guardian Executor Power of Attorney Other: _____

Witness: _____ Date: _____