ORION FAMILY HEALTH
Phone: 954-667-7336
Fax: 954-405-8852
Medicine. The way it should be.

Medical Records Release Authorization

I hereby authorize _____ (medical facility) to release my individually identifiable health information as outlined below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory and imaging reports, medical history, treatment, and any other such related information. I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____ _____ _____
Patient name (please print) Date of birth Social Security Number

_____ _____
Address (including City, ST, and zip code) Phone number

Information to be released:

◯Complete records from _____ to _____, including lab and imaging reports

◯All vaccinations ◯All preventive measures (colonoscopies, mammograms, paps, etc.)

◯Other

_____

Purpose of releasing records (circle): Transfer of care (or _____)

Please release the above information to Monica Bartoli, D.O at Orion Family Health (address and numbers below)

_____ _____
Signature Date

_____
Patient Name (printed)

Circle: Self / Other:_____
Relationship to Patient (legal authority if minor, attach supporting documentation)