DESTINATION CARE FAMILY PRACTICE, LLC
14601 SW 29th Street, Suite 302
Miramar, FL 33027
Phone: 954-526-6890 Fax: 754-484-1337
Dcfamilypracticefl@gmail.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENE NAME_____
Last Name (Họ) First Name (Tên) Middle Initial (Tên lót)

HOME ADDRESS_____
Street Address (Địa chỉ)

_____
City (Thành phố) State (Tiểu bang) Zip Code(Mã bưu điện)

_____
Date of Birth (Tháng/Ngày/Năm sinh)

I hereby request _____

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

To furnish a copy of <u>ALL Available Medical Records</u> of the patient named above to Destination Care Family Practice.

Purpose or Need for Disclosures: **CONTINUED PATIENT CARE**

_____ I authorize the release of all information, including information regarding HIV testing, AIDS
Initials information, substance abuse, alcohol use, psychiatric disorders and psychological disorders that may be included in my medical record. I hereby release your physician and staff from liability following this authorization and release

_____ _____
Signature of Patient/Parent/Conservator/ Guardian (Chữ ký của Bệnh nhân) _ Authority/Relationship to Patient

_____ _____
Witness Signature (Chữ ký người làm chứng) – Date (Ngày)