AUTHORIZATION TO RELEASE MEDICAL INFORMATION (to get information from your previous and / or current physician for our providers)

HEALTHCARE PROVIDER'S NAME:

Phone Number: ( ) _____

Fax Number: ( )

Email: _____ @ _____

I, hereby authorize you to release medical records and / or any information including diagnosis or any treatment or examination rendered to include any condition or diagnosis relating to Alcohol Abuse, Drug or substance Abuse, HIV testing or Results, or Mental Health Conditions. Please include other Physician's medical records.

Patient: _____

Date of Birth: _____

X ----------

Signature of Patient (Parent or guardian of minor child) Date

☐ Send all records to:

Associated Family physicians of Boca Raton, P.L.
9910 Sandalfoot Blvd., Suite 1
Boca Raton, FL 33428-6692
561-883-3030 - 561-852-7611 fax

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