AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Dawson Integrative Medical Center, LLC.
3203 South Conway Road Suite 204-A
Orlando, FL 32812

Patient Name: _____Date of Birth: _____

Address: _____

Phone: (____) _____-_____

I authorize Dawson Integrative Medical Center, LLC to release information about my medical condition and diagnosis (including treatment, payment, and health information) to the following family member or other persons (if any):

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

I understand that these records may contain information from other health care providers, as well as information which is administrative in nature. I specifically consent to the release of any information contained in my medical record which may relate to:

_____Infection with Human Immunodeficiency Virus (HIV) _____ AIDS _____ Mental Health and any other related alcohol and substance use.

I understand that you have no responsibility of the use of distribution of this information by the party to whom it is released. I release you form all liability which may arise from your compliance to release records.

I authorize you to transmit this information by telephone, facsimile transmission (fax) and/or mail, and to release you form any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax.

This release is valid for 1 year from the date signed.

_____ _____
Patient / Legal Representative Signature Date