Mail To: **LAKE MARY FAMILY PHYSICIANS**
910 Williston Park Point, Suite 2050
Lake Mary, FL 32746

Or Fax To: 407-829-8978 Phone: 407-829-8960

AUTHORIZATION TO OBTAIN / RELEASE MEDICAL RECORDS

I, _____ for _____
Name of Patient / Guardian **Name of Patient**

Date of Birth _____ Social Security Number _____

give authorization for Lake Mary Family Physicians P.A. to release to and / or obtain my protected health information / medical records from the following Physician and / or Facility.

_____
(Name / Physician / Facility / Agency / Organization)

_____
(Complete Address)

_____
(Phone Number / Fax Number)

THE PURPOSE OF THE USE OR DISCLOSURE IS *(Please check(√) all that apply)*:					
	Continued Patient Care		Attorney / Legal		Social Services / Disability
	Insurance		Personal Use		Patient Transferring PCP
	Patient Moving		Other:		Other:

Please ONLY send LAST "2" years of the following records: OFFICE NOTES, PROBLEM LIST, IMMUNIZATION RECORD, PERTINENT LABS, IMAGING & DIAGNOSTICS REPORTS

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials or check (√) mark on the lines below authorize the release (if applicable) of information pertaining to:
(__) Alcoholism and / or Drug abuse * (__) Mental health and / or rehabilitation * (__) HIV / AIDS / Sexually Transmitted disease & testing for other communicable diseases

I understand that this information will be used solely for professional purposes, will remain confidential and may not be disclosed to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance thereon. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

_____ _____
Print Patient Name **Signature of Patient / Guardian**

_____
Date