AFM HEALTHCARE
Giving you a LIFETIME OF CARE

Phone Number: Winter Park: 407-657-2111 ***Oviedo:*** *407-537-9852* ***Lake Nona:*** *407-657-2111*
Fax Number: 866-725-4812
Location:
Winter Park: 7221 Aloma Ave, Suite 200, Winter Park FL 32792
Oviedo: 1410 W. Broadway St., Suite 201, Oviedo FL 32765

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION/MEDICAL RECORDS

Patients Name: _____ DOB:_____
Telephone No. _____ SS#:_____

I hereby authorize AFM HEALTHCARE to:

o Request Information from o Release Information to

NAME/ORGANIZATION: _____ TEL. _____
ADDRESS: _____ FAX: _____

PLEASE RELEASE THE FOLLOWING:

___ All records in the past 2 years of treatment
___ Lab Results/Pathology Reports
___ Radiology Reports
___ Drug abuse
___ Alcohol abuse
___ Mental health
___ HIV test results
___ Immunization Records
___ Pharmacy/Prescription Records
___ Others: _____

*NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, Ca DX, Drug/Alcohol abuse, or sexually transmitted disease, you are hereby authoring disclosure of this information.

REASON FOR RELEASE/ REQUEST:

___ Continuation of patient care ___ Personal Use ___ Attorney/Legal
___ Specialist Consult ____ Other: _____

RELEASE BY: *only use this for release of information only*

___ FAX
___ EMAIL: _____ ENCRYPTED [ ] YES [ ] NO
___ PRINT

Consent:

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization at any time in writing. I have the right to receive a copy of this information. I understand that I may be charged for copies provided, for personal use ($1/page for the first 25pgs and $0.25 per page thereafter). This authorization is valid for one year from the date it was signed.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient or Legal Representative