1600 36th Street Suite B
Vero Beach, FL 32960
(772) 567-1164
Fax: (772) 567-1501

Authorization to Release Medical Information / Records

PLEASE PRINT CLEARLY

Patient name ____
Last First Initial

Date of Birth __________Social Security #__ ___________________Phone #______________

Release records FROM :

Address ____
Releasing Doctor
____
Street
____Phone ____________________
City Zip

Release records TO:

Address ____
Recipient Doctor
____
Street
____Phone ____________________
City Zip

Release records Via: *MINIMUM OF 1-2 DAYS FROM DATE OF REQUEST*

MAIL TO (Name / Address): ____

FAX TO (Name / Fax #): ____

PICK UP (Phone number to call when records are ready for pick up): ______________________________

__________ I consent to release information regarding **Substance Abuse**
(initials)

__________ I consent to release information regarding **Mental Health**
(initials)

__________ I consent to release information regarding **HIV / AIDS**
(initials)

I understand that I may revoke this consent any time prior to the actual sending of the medical information.

____ ______________________
Patient or Legal Representative Signature Date