Authorization for Release Medical Records
Please fax records to: 407-778-1479

Patient's Name: _____ DOB: _____ SSN#: XXX-XX-___

I give Vip Walk in Clinic authorization to:

___Release my medical records to: _____
___Obtain my medical records from: _____
___Discuss my medical records with: _____

Address: _____
Phone: _____ Fax: _____

Information to be disclosed:

__Lab Results	__Pathology	__Mammogram/PAP
__X-ray Reports	__Progress Notes	__Colonoscopy
__Procedure Reports	__Emergency Room Records	__Other:
__Most Recent Only	__All dates of service	__Date of service:

Purpose of Disclosure:

__Continuing care with a new or Other physician of hospital	__Personal Copy	__Other:

I understand that: Information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. This authorization will remain in effect for twelve months from the date signed. I may revoke this authorization and that it is strictly voluntary. If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. If I do not sign this form, my health care and payment for my healthcare will not be affected.
That I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
This release will be effective from the date of signature.

_____ _____
Patient/Guardian/Representative Signature Date

_____ _____
Witness Signature Date

(FOR OFFICE USE ONLY) Records released by: Fax/Mail/Given to patient on: _____ Initials: ____

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