RELEASE OF MEDICAL RECORD

Patient's Name (PRINT) _____ Phone Number _____

Social Security Number _____ Date of Birth _____

I hereby authorize Name :_____ phone:_____
Address:_____Fax:_____

To release my medical records, this medical information should be released to physician listed below:

Bon Vitas Medical

□ **12200** W. Colonial Dr Suite 202, Winter Garden FL 34787

Ph. 321-270-5976 **Fax 321-270-5978**

Check off items being released:

	All medical records		Hospitalizations
	Lab Reports		Consult Notes
	Radiology Reports		Other:
	Immunizations		Most Recent Physical

I, _____, authorize the release of alcohol and /or drug abuse treatment and information. FL Patient's Signature Statute 397.053 and 396.112 and the federal Alcohol and Drug Abuse Act protect confidentiality.

I,_____, authorize the release of HIV test results and /or HIV treatment informati on, AIDS Patient's Signature and related conditions. Confidentiality is protected by FL Statute 381.609(2).

I,_____, authorize the release of psychiatric information. FL Statute 394.459(g) protects Patient's Signature confidentiality.

- ❑ In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Bon Vitas Medical, LLC and its staff from any restrictions or privilege imposed by law in connection with the disclosure or release of any professional record, observation, or communication.
- ❑ I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected.

This authorization may be revoked writing at any time, except that Bon Vitas Medical, has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Bon Vitas Medical, LLC, 12200 W. Colonial Dr Suite 202, Winter Garden FL 34787. If not previously revoked in writing, this authorization will not have an expiration date.

Signature of Patient of Authorized Representative X_____ Date X_____

Relationship to Patient _____