ORLANDO FAMILY PRACTICE CARE, P.A.
Board Certified Family Practice
10967 Lake Underhill Rd Suite 122
Orlando, FL 32825
P: 407-282-3131 F: 407-282-3139

MEDICAL RECORD RELEASE/OBTAIN FORM

Patient's Name:_____ Date of Birth:_____

Patient's Address:_____ Phone Number:_____

Reason for my request: (Please check all that apply)

_____ Transferring Medical Care _____ For my own personal records

_____ Continuation of Care by Specialist _____ Moving

Records to be Released/Obtained: (please check all that apply)

_____ All Medical Records _____ Office Notes _____ Radiology/Imaging

_____ Laboratory/Pathology Reports _____ Diagnostic testing _____ Consults

Sensitive Information:

_____ Drug Abuse _____Psychiatric/Psychological treatment _____ HIV/AIDS diagnosis _____ Alcohol abuse

Transfer my records via: (please check one)

_____ Fax _____ Mail _____ Pick Up

_____ RELEASE

I authorize Orlando Family Practice Care, P.A. to release my healthcare information to:

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

_____ OBTAIN

I Authorize:

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

To release my healthcare information to:

Name: ORLANDO FAMILY PRACTICE CARE, P.A.

Address: 10967 LAKE UNDERHILL RD STE 122 City: ORLANDO State: FL Zip code: 32825.

Phone: 407-282-3131 Fax: 407-282-3139.

I acknowledge that this consent will expire in 30 days after the date of signature, or automatically when the records requested have been mailed, faxed, or picked up.

**** Please note: There is a charge for record release of $1.00 per page for the first 25 pages, and $0.25 for each additional page. If records are released electronically, the charge will be $25.00 per CD. Prepayment is required before records are released.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Staff witness's Name	Staff witnesses' Signature	Date