Florida Arthritis Center, PL
147 Parliament Loop, Suite 1005
Lake Mary, FL 32746

FLORIDA ARTHRITIS CENTER

Florida Arthritis Center, PL
609 N. Charles Richard Beall Blvd.
Debary, FL 32713

Telephone: 407-688-9446 Fax: 407-688-9448

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I_____Name of Patient / Guardian Name of Patient

Date of Birth_____ Social Security Number _____ give authorization

for Florida Arthritis Center, PL to release to/ or obtain my protected health information/ medical records from the following Physician and/ or Facility.

(Name/ Physician/ Facility/ Agency/ Organization)

(Complete Address)

(Phone Number/ Fax Number) THE PURPOSE OF THE USE OR DISCLOSURE IS (Please check (✓) all that apply):		
Continued Patient Care	Attorney / Legal	Social Services / Disability
Insurance	Personal Use	Patient Transferring PCP
Patient Moving	Other	Other

Please ONLY send the following records: OFFICE NOTES, PROBLEM LIST, PERTINENT LABS, IMAGING & DIAGNOSTICS REPORTS *I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials or check (✓) mark on the lines below authorize the release (if applicable) of information pertaining to:*
( ) Alcoholism and/ or Drug abuse* ( )Mental health and/ or rehabilitation* ( ) HIV/ AIDS/ Sexually Transmi!1ed disease & testing for other communicable diseases.

I understand that this information will be used solely for professional purposes, will remain confidential and may not be disclosed to third parties. This authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance there on. I permit this authorization for a period not to exceed one year. I understand that a copy of this release is as valid as the original. In consideration of this consent, I hereby release the above parties from any and all liability arising the reform.

_____ _____
Print Patient Name Signature of Patient / Guardian

Date_____