

20212 E. Pennsylvania Ave Suite B
Dunnellon, Florida 34432
Tel. 352-484-0422
Fax: 352-484-1430

Client's Name: _____
SS#: _____
DOB: _____

Before signing, Cross Out Any Part(s) That do(es) Not Apply

Consent for release of medical information

Florida law requires that information contained in medical records be held in strict confidence and not be released with or without your written authorization. The authorization you sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at anytime. You have a right to receive a copy of this authorization upon request.

Authorization for release of medical information

I, _____ authorize _____
(Name of patient/legal representative) (Agency/individ. In possession of record)
to release (initial by {a,b,c,d,e,f,g,h,i} any or all that apply):

- a. The general medical record created at the medical facility. *Past year*
- b. The following information from the medical or case management record:

- c. Records obtained from the following providers:

- d. STD records e. TB records f. HIV/AIDS records
- g. Drug/alcohol treatment records h. Psychiatric/psychological information
- i. Adult and child abuse information

to: **Advantage Primary Care**
for the purpose of: CONTINUATION OF CARE

Date: _____ Signature of Patient/Legal Guardian: _____

Witness: _____
(Legal Guardian's relationship to patient)

Dr. Phone: _____

Dr. Fax: _____

Dr. Address: _____