FAMILY MEDICAL GROUP, P.A.

Wilfred Corredera, MD
Daniel E. Montero, MD

Cheryl A. Carter, APRN
Heidi Smith, APRN

☐ **113 Health Way**
Lake Placid, FL 33852
863-465-7010
Fax: 863-465-4223

☐ **3420 US Hwy 27 North**
Sebring, FL 33870
863-385-7077
Fax: 863-385-6863

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

☐ I herewith authorize **release to** Family Medical Group, P.A. from: **OR** ☐ I herewith authorize Family Medical Group, P.A., **to release to**:

Name: _____

Address: _____

City:_____ State/Zip:_____

Phone Number: _____ Fax Number: _____

Medical information pertaining to my care for the purpose of: _____

Initial all that pertain:

____Copies of all medical records pertaining to my care ____Laboratory/pathology reports ____X-ray reports ____Progress notes

____Other diagnostic tests _____ ____Consultation Reports ____Verbal discussion/conference

____Other_____ ____Substance Abuse Records ____ HIV / AIDS Records ____ Mental Health Records

Time Frame of Request: ____One Year of Documents (most current) ____ Two Years of Documents ____Three Years of Documents

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- ❖ We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- ❖ You may inspect a copy of the protected health information to be used or disclosed;
- ❖ You may refuse to sign this Authorization;
- ❖ You are entitled to a copy of the signed authorization;
- ❖ Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

I release **Family Medical Group, P.A.** from any and all legal responsibility or liability that may arise from this authorization. This authorization is effective through _____/_____/_____. You may revoke or terminate this authorization earlier by submitting your request in writing to the office marked above: Attention Front Desk Receptionist.

Patient
Name:_____ DOB:_____Signature: _____

Phone Number(s) where you could be reached:_____

Patient
Legal Representative:_____ Signature: _____

Witness:_____ Date:_____

Allow 7 working days for the processing of this request**