15820 Shaddock Drive #130
Winter Garden, Florida 34787
Phone: 407-401-8855 Fax: 407-347-5463
Email: admin@wghw.health

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
NO CD MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____

Phone: _____ _____**Email:** _____

INFORMATION TO BE RELEASED:

Dates: _____ **to** _____

____Office Notes ____Radiology Reports ___Pathology Reports ____Diagnostic Results ___All Records

_____I do _____I do not authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care, and/or psychological assessments, and treatment for alcohol and/or drug abuse.

PURPOSE OF DISCLOSURE:

____Continued Treatment ____Insurance ____Personal Use ____Disability ____ Legal ____Other

Please release my health information from the following providers/facilities:

Name: _____ **Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:**_____

Fax: _____ **Fax:** _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form may be revoked in writing and otherwise expires five years from the date listed below.

Patient Signature: _____ **Date:** _____