825 Oakley Seaver Drive
Clermont, FL 34711
Tel: 352-536-1764 * Fax: 352-536-1765

MEDICAL RECORDS RELEASE

I, _____ for _____
Name of Patient / Guardian **Name of Patient**

Date of Birth _____Social Security Number _____

Give authorization for Physicians Medical Group, LLC to: CHECK ONLY ONE

___ Release my medical records to
___ Obtain my medical records from
___ Discuss my medical record with

Name of person or facility Sending and / or Receiving: _____

Address: _____

Phone and Fax Number(s) _____

THE SPACES BELOW GIVE SPECIAL AUTHORIZATION FOR THE RELEASE OF SPECIFIC CATEGORIES OF INFORMATION
Please Initial each line
_____ Medical information regarding SUBSTANCE ABUSE (if applicable) may be released to the recipient noted above.
_____ Information regarding MENTAL HEALTH/REHABILITATION (if applicable) may be released to the recipient noted above.
_____ Information regarding HIV/AIDS and/or SEXUALLY TRANSMITTED DISEASE (if applicable) may be released to the recipient noted above.
_____ Information regarding PREGNANCY if patient is under the age of eighteen (18)

NOTE: Only a limited medical summary will be sent if all the above consents are not initialed or checked.
I understand this consent is revocable by me, in writing, at any time except after the action has taken place. I also understand that this consent will expire **1 YEAR** after the date of signature **OR** automatically when the records requested on this form have been mailed/received to/from the above requested facility.

Date_____ Signed: _____ (Patient)

Signed _____(Guardian)

Signed _____(Witness)