AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____

Date of Birth: _____ SS#: _____

Patient's Address:

_____

_____

The undersigned authorize and/or request Affordable Care Clinics to:

❑ OBTAIN FROM:

❑ RELEASE TO:

Person/Organization Name: _____

Address: _____

Phone/Fax: _____

Please DO NOT release the following:

_____

_____

- Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment, and/or examination related to mental health care, drug and/or alcohol use, HIV/AIDS testing, and sexually transmitted diseases.
- By signing this release, I understand that this authorization will remain in effect for 90 days or until revoked in writing.
- I understand that state law prohibits the re-disclosure of the information disclosed to the person/entities listed above without my further authorization, but that Affordable Care Clinics cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.
- I hereby release Affordable Care Clinics and the employees of Affordable Care Clinics from any liability that may arise from the release of information as I have directed.

X_____ _____

SIGNATURE DATE

X _____ _____

EMPOWERED REPRESENTATIVE/ GUARDIAN DATE

IF THE RECORDS ARE MORE THAN 10 PAGES, KINDLY MAIL TO FOLLOWING LOCATIONS: (Circle Location)

Avalon Medical Walk in Clinic
14807 E. Colonial Dr., Ste. 112
Orlando, FL 32826
Main Line: (407)-250-6742
Fax: (407)-203-6747

Sandlake Medical Walk in Clinic
1650 Sand Lake Rd., Unit 112a
Orlando, FL 32908
Main Line: (407)-286-1829
Fax: (407)-286-3291

Malabar Medical Walk in Clinic
1663 Georgia St., Ste. 500
Palm Bay, FL 32907
Main Line: (321)-802-9080
Fax: (321)-802-5211