Medical Associates
OF CENTRAL FLORIDA

Amy Davis, MSN APRN
Primary Care

Mahesh G Allam, MD
Internal & Pulmonary Medicine
Sleep Disorders

Nakisha Watson, ARNP
Primary Care

Authorization For Release Of Information

I,_____ hereby give my consent of release to/from:

1. Information to be released from

Doctor/Facility:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____Date:_____

2. Information to be released from to:

Doctor/Facility:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____Date:_____

3. Information to be released on the following patient:

Name of Patient:_____

Date of Birth:_____Social Security No.:_____

4. Date(s) of treatment: (__) All Dates (___) Specific Dates _____

5. Information to be released (including STD, HIV, Drugs, HepB and HepC, Psychiatric/Psychology):
(__) All Records (__) Progress Notes (__) Labs (__) Radiology (__) Operative

6. Purpose of Disclosure: (__) Medical Records (__) Other _____

This authorization shall be in effect for 90 days following the date of signature below. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A photocopy of this authorization shall constitute a valid authorization.

The facility, its employees, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient or Representative:_____

Relationship to Patient:_____

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