WEST MARION FAMILY PRACTICE

Dr. Carlos Lara   Dr. Ivette Colon   Dr. Andrew Pogiatzis

8599 SW HWY 200 Ocala, FL 34481 Tel. 352-861-0043 Fax: 352-861-8750

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_______________________________________

Date of Birth:____

I request and authorize West Marion Family Practice to:

[ ] Obtain records FROM: _______________________________________

Address: ____

Phone: ____________________________ Fax: ______________________________

OR

[ ] Send records TO: ____

Address: ____

Phone: __________________________ Fax: __________________________

Healthcare information relating to the following:_________________________

Most Recent Office Notes, Labs, Imaging

OTHER:____

The release of health information is at the request of the patient. By providing this authorization, I understand the following:

• I understand that this authorization is voluntary

• I understand that I may revoke this authorization at any time by notifying provider in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation

• I understand that the health information to be released may be subject to disclosure by the recipient of the health information and no longer protected by the federal privacy rules.

• . YES___ NO___ I authorize the release of my sexually transmitted diseases and HIV/AIDS results, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

YES___NO___ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature______________________________ Date Signed______________________