☐ Dr. Carlos Lara ☐ Dr. Yoany Guia ☐ Dr. Andrew Pogiatzis ☐ Dr. Eldere Germain
☐ Roberto Alvarez Garcia ARNP

8599 SW HWY 200 OCALA, FL 34481 Phone: (352) 861-0043 Fax: (352) 861-8750
2760 SE 17th St #400 Ocala, Fl 34471 Phone: (352) 245-1845 Fax: (352) 433-1381

Medical Release Form

Patients Name:	**DOB:**

I request and authorize Lara Medical & Associates to:

Obtain records from:	
Address:	
Phone:	**Fax:**

Send records to:	
Address:	
Phone:	**Fax:**

Healthcare Information relating to the following: Most Recent Office Notes, Labs, Imaging etc.

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 disease and HIV/AIDS results, whether negative or positive, to the person(s) listed above.

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

Patient's Signature:	Date: