Orlando Arthritis and Rheumatology Clinic
7932 West Sand Lake Road, Suite 200
Orlando, FL 32819
PH: 407-355-7759 FAX: 407-355-4987

Authorization for Release of Medical Records

Patient Name: _____ D.O.B.: _____ DOS: _____

I hereby give my consent to Orlando Arthritis and Rheumatology Clinic and authorize the release of all medical records regarding my illness/ treatment including all reports of diagnosis, treatment, prognosis, recommendations and other pertinenet data as indicated to the requesting physician. Please forward all records to:

Name:_____

Address: _____

Phone: _____ Fax: _____

Treatment period from:_____ Treatment period to:_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon authorization. The authorization will expire six months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____Printed Name: _____ Date: _____