Good Health Physicians

Medical Release Consent Form

217 E Central Ave
Winter Haven FL, 33880
PHONE:863-229-2540 **FAX:**863-229-1230

I_____ authorize my medical records to be released from the named health care provider below.

Social Security#_____ DOB_____

Previous Provider Name: _____

Phone:_____ Fax:_____

Records Authorized to be release:

- ❑ Lab Reports
- ❑ Radiology
- ❑ Last visits Note
- ❑ Substance Abuse
- ❑ Mental Health
- ❑ Other : (specify)_____

The purpose of this request is for continued medical care.

I Understand that the information contained in my medical records may include records pertaining to diagnosis, evaluation or treatment of any mental or emotional condition or disorder including alcoholism and/ or drug addition and may also containing information regarding test results for AIDS/HIV or infection with any probable causative agent of AIDS. I understand the expiration date of this is one year. I understand that i may revoke this authorization at any time by notifying the provider and it will be effective on the date notified expect to the action has already been taken. I understand the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by Federal privacy regulations. I understand by authorization and this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand i have the right to receive a copy of this form after i have signed it. I also understand that in compliance with Florida Law, I may be required to pay a fee for for retrieval and photocopying of records and /or supervising inspection of medical records. This authorization will expire one year from the date of the signature below. I understand that i can revoke this authorization at any time by letting my healthcare provider know but the revoking of this authorization will not affect disclosure made or actions taken before the revocation is revoked.

Signature:_____ Date:_____