PINKAL PATEL, MD – FAMILY MEDICINE
GIGI MANIAR, MD – PEDIATRICS
KATHRYN GRAVES – ARNP
KAREN MOUNGER – ARNP
ERICA KINDIG – ARNP

OVIEDO FAMILY HEALTH CENTER

O·F·H·C

Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____

I authorize and request the release of all medical records regarding my medical history, treatment and results of any testing done, including HIV, for the purpose of ongoing medical care.

Comments: _____

Release to: Oviedo Family Health Center, 6012 Aloma Woods Blvd., Oviedo, FL, 32765

Fax # 407-359-8410 **Phone # 407-366-7455**

Release from: _____ **Phone:** _____

Fax: _____ **Address:** _____

City: _____ **State:** _____ **Zip:**_____

Purpose of Authorization: _____

_____

This authorization expires on _____**,** 20__

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying **OFHC** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature: _____ **Date:** _____