Heart and Vascular Care, PA
Strong Heart and Walk Free

Consent For Release of Confidential Information

Patient's Name _____ DOB _____

I authorize and hereby request that a copy of my medical records be released as follows:

INFORMATION TO BE RELEASED TO:			**INFORMATION TO BE RELEASED FROM:**		
HEART AND VASCULAR CARE, PA					
Name			Name		
1277 N Semoran Blvd, Suite 101					
Address			Address		
Orlando	**FL**	**32807**			
City	State	Zip	City	State	Zip

☐ This release is to cover ALL records contained in my file.
☐ This release is to cover the following specific records:

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 addiction. May also contain information regarding test results for AIDS, HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____ _____
Witness Date