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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I _____ hereby authorize Surgical Associates of Central Florida, P.A. to obtain records on my behalf from:

Please release my complete medical records including medical, drug or alcohol abuse and HIV testing.

Any portion of the medical record may be withheld according to additional instructions indicated on this release. This release is valid for one year and may be revoked at any time upon written notification from the patient.

Use or disclosure of Protected Health Information made according to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule 45 CFR Part 164.

Date

Signature of Patient or Personal Representative

Date of Birth

Printed Name

Social Security

Address