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RELEASE OF MEDICAL RECORDS

I _____ hereby authorize Surgical Associates of Central Florida, P.A. to release my complete medical records including medical, drug or alcohol abuse and HIV testing to:

_____ Name

_____ Street

_____ City, State and Zip

Attention: _____

Fax No. _____

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