VascularSpecialists
of Central Florida, Inc.

Medical Record Release Form

Patient Name: ______________________________

Date of Birth: ______________________ Social Security #: ______________________

By signing this authorization, I authorize Vascular Specialists of Central Florida, Inc. to obtain / release (please circle that which applies) certain protected health information (PHI) about me from/to:

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(Name and address of entity being asked to release information or the entity to which the information will be forwarded)

The information requested to be obtained from the entity listed above should be sent to:

Vascular Specialists of Central Florida, Inc.
80 West Michigan Street
Orlando, Florida 32806
Ph 407-648-4323 Fax 407-839-1493

This authorization permits the following individually identifiable health information about me to be obtained/released:

- ☐ My complete medical record
- ☐ Visit services provided by only the following physician(s) or other practitioner(s) ______________________________
- ☐ Office/Outpatient/Inpatient Diagnostic Testing
- ☐ Medication Lists
- ☐ Laboratory Results
- ☐ Alcohol and/or drug abuse
- ☐ HIV testing/diagnosis
- ☐ Operative reports for invasive/surgical services
- ☐ Other ______________________

The information will be used or disclosed for the following purpose: (check one)

- ☐ My records only
- ☐ Transferring Care to ______________________________
- ☐ I am moving out of area.

My new address is: ______________________________

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Signed: ______________________________ Today's Date: ______________________

Signature of Patient

______________________________ ______________________________

Signed by Personal Representative/Guardian (if applicable) | Print Personal Representative/Guardian Name Relationship to Patient

For Internal Purposes Only

Completed by: ______________________ Date completed: ______________________

Fax ☐ Pick-up ☐ Mailed ☐ Other ☐