Access Family Care, LLC
712 West 25th Street, Sanford, FL 32771
www.accessfamilycarefl.com
Phone: 407-402-2303; Fax: 407-321-0461

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: __ /__ /____

Last (Four) of SSN #: _____

Please list the name of your previous physician in order to obtain medical history:

Name of Doctor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

PURPOSE OF DISCLOSURE: *Select all that may apply*

____ Continuing care with other physician ____ Personal Copy ____ Other: _____

INFORMATION TO BE DISCLOSED:

____ Complete Records ____ Consultation ____ Other: _____

____ Progress Note ____ All Diagnostic Test Results

____ Lab Only ____ ER Documentation

I understand that any alcohol, drug abuse, mental health, psychotherapy, and HIV/AIDS related information, if present, will be disclosed with this authorization, unless excluded here: _____

Note: Access Family Care reserves the right to charge you to have your records printed and/or transferred. The processing time for medical records requests will vary depending on what records are requested and the reason for the request. Complete medical record request may take up to the legal 30 days allowed. By signing this release form, you are agreeing to compensate AFC, LLC for all charges incurred in the printing of your medical records. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has already been taken in reliance on this authorization and that this authorization shall remain in force for a 90 day period in order to effect the purpose for which it is given.

Patient (or Representative) Signature: _____ Date: _____