J&J Healthcare Institute, Inc.
1410 North Pine Hills Rd
Orlando, Florida 32808
Ph: (407) 839-3363 Fax: (407) 839-3364

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____ DATE:_____

DOB:_____ SS#:_____-_____-_____ PHONE#:_____

ADDRESS:(street)_____

CITY_____ STATE_____ ZIP_____

BY STATE LAW YOU MUST BE INFORMED THAT: The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as 'AIDS'.

I hereby authorize: Facility:_____

_____

_____

Phone: _____ Fax:_____

To release the following health record(s) information of the above-named patient, for the following purpose:

[ ] Externship use [ ] Director's use [ ] Other:_____

Information to be released:

[ ] History & Physical exam [ ] Consultation [ ] X-ray reports

[ ] Operative Reports [ ] Lab/Pathology

[ ] Other: _____

This information is to be released to: J&J Healthcare Institute, Inc.
1410 North Pine Hills Rd
Orlando, Florida 32808
Ph: (407) 839-3363 Fax: (407) 839-3364

Disclosure: This information is being disclosed to the above Institute from records whose confidentiality is protected.

_____ _____

Patient/Legal Guardian Signature Date