Medical Records Release Form

Patient Information:

Patient's Full Name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email Address:** _____

I, the undersigned, hereby authorize the release of my medical information to the following individual(s) or organization(s):

1. **Name:** _____

   Relationship to Patient: _____

   Contact Information: _____

2. **Name:** _____

   Relationship to Patient: _____

   Contact Information: _____

Purpose of Release: _____**TRANSFER OF CARE**_____

I understand that the information released may include, but is not limited to, medical records, test results, treatment summaries, and any other pertinent medical information.

I authorize the release of this information from:

Healthcare Provider Information:

Healthcare Provider's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

To:

Recipient's Name/Entity: _____Horizon West Pediatrics Center _____

Address: _____5730 Hamlin Groves Trail Ste. 164_____

City: _____Winter Garden_____ State: ____FL_____ Zip Code: ___34787____

Phone Number: ____407-347-7052_____ Fax Number: ____321-282-6944_____

This authorization is valid from _____ to _____ unless revoked earlier in writing.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on it, by providing written notice to the healthcare provider.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient's Signature: _____ Date: _____

Witness (if applicable): _____ Date: _____