

ORLANDO FAMILY PRACTICE CARE, P.A.
10967 Lake Underhill Rd Suite 122
Orlando, FL 32825
P: 407-282-3131 F: 407-282-3139



MEDICAL HEALTH INFORMATION RELEASE/AUTHORIZATION

I, _____ authorized Orlando Family Practice Care, P.A., its physicians, and staff members to release any medical records and health information to the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand that by signing this release, the individuals listed above have the right to receive any information whether electronically, on paper, or orally. They are also authorized to schedule and/or cancel any appointments on my behalf. Such consent will remain effective until I revoke it.

Patient's Signature

Date

Witness Name

Witness Signature

Date