Office of Robert K. Law, D.O., P.A.
3151 N. Alafaya Trail, Suite 101
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Authorization to Release/Obtain Medical Records

PATIENT NAME:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #:_____/_____/_____

Release FROM:

Name_____

Address:_____

City/State/Zip:_____

Phone #:_____ FAX#:_____

Release TO:

Name:_____

Address:_____

City/State/Zip:_____

Phone#:_____ FAX#:_____

I ONLY AUTHORIZE RECORDS INITIALED

_____ Immunization
_____ Diabetic Record
_____ Tuberculosis Record
_____ X'ray Reports
_____ Laboratory Reports
_____ EKG
_____ Medication List
_____ History & Physical
_____ Discharge Summary
_____ Consults
_____ Psychiatric Records
_____ Alcohol & Drug Abuse Information
_____ HIV/AIDS Information
_____ Complete Medical Records

Authorization to permit disclosure of medical records

I, the undersigned, do hereby authorize the ablove physician, hospital, or clinic to release copies of any and all medical, psychiatric, drug and /or alcohol abuse and AIDS information in my medical records as I have directed.

_____ _____

Signature of Patient/Guardian **Date** **Witness** **Date**