ANASTASIA FAMILY CARE
AUTHORIZATION TO RELEASE INFORMATION
PLEASE PRINT CLEARLY

Patient Name:____
Last First Initial

Address:____
Street City State Zip

Phone (___)_________________________ DOB: __________________ SS# _____________________________

____
NAME OF PREVIOUS PROVIDER ADDRESS PHONE

____
NAME OF PREVIOUS PROVIDER ADDRESS PHONE

I authorize the above named previous provider to release medical information from my medical records to:

ANASTASIA FAMILY CARE
103 Anastasia Blvd.
Saint Augustine, FL 32080
PH (904) 825-4747
FAX (904) 825-2885

For the purpose of review/examination and further authorize you to provide such copies thereof as many be requested.

The foregoing is subject to such limitations as indicated below:

☐ Entire Record ☐ Specific Information: _____________________ ☐ Old Records from Previous Physicians

I give special permission to release any information regarding: (initial on line(s) below that you grant us permission to release the information to the above)

__________ Substance Abuse __________ Psychiatric/Mental health Info. ____________ HIV Info.

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken to reliance thereon.

Reason for Request: ____

Signed: ____
(IF NOT PATIENT, STATE RELATIONSHIP) DATE

Witness: ____

FOR OFFICE USE ONLY

Received: ____________________________________

Completed: __________________________________

Completed: ______________________________

Fee Paid: ________________________________

Amount Due/Billed: _______________________