TRINITY FAMILY MEDICAL CENTER, P.A.

STEPHEN E. YOUNG, D.O.

Consent for Release of Confidential Information

Patient's Name _____ DOB _____

I authorize and hereby request that a copy of my medical records be released as follows:

INFORMATION TO BE RELEASED TO:	***INFORMATION TO BE RELEASED FROM:***
TRINITY FAMILY MEDICAL CENTER, P.A Name	_____ Name
1707 Mayo Drive Address	_____ Address
Tavares FL 32778 City State Zip	_____ City State Zip
(352) 253.2511 Telephone	_____ Telephone
(352) 253.2522 Fax	_____ Fax

☐ This release is to cover ALL records contained in my file.
☐ This release is to cover the following specific records:

Please mail do not fax if more than 10 pages.

The purpose of this request is for continued medical care.

I understand that the information contained in my medical records may include records pertaining to diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, including alcoholism and/or drug addiction. May also contain information regarding test results for AIDS, HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____ _____
Witness Date