

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

