Eduardo L. Gonzalez, MD
Florida Urgent & Family Care
PO Box 5399
Niceville, FL 32578
frontdesk@floridaurgent-familycare.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:	Date of Birth:
(Previous Name):	Social Security #:
I request and authorize Florida Urgent & Family Care to release healthcare information of the patient named above to: (Include email address if requesting records to be sent to you via encrypted email.There is no charge for electronic records sent via email or fax.)	Name Street address City, ST ZIP Code FAX or Email record to:

This request and authorization applies to:

____ All healthcare information

____ Specific healthcare information. List:

_____I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

_____I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.