

Vitality Health & Wellness, LLC

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(305) 466-1100 Fax: (305) 466-1160

MEDICAL RECORDS RELEASE FORM

This authorizes Vitality Health & Wellness, LLC to release medical records for:

Patient Name

I hereby authorize Vitality Health & Wellness, LLC to release the complete medical record(s) and/or information from my medical record (FL Statute 455.241) as well as psychiatric/psychological information, alcohol and/or drug information (FL Statute 395.459 and Fed. Reg. 42CFA, Part II), and Human Immunodeficiency Virus (AIDS) tests and other information (FL Statute 381.004) pertaining to these tests or to the treatment in connection with these test results.

I further release Vitality Health & Wellness, LLC, their practitioners and representatives from any legal responsibility and/or liability that may arise from the release of such records as specified above and I hereby waive all rights I have to the preservation of their confidentiality.

FAXING OF HIV RESULTS IS NOT PERMITTED

Please send the following information:

- | | | |
|--|---|--|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Practitioner Notes | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Diagnostic Tests | <input type="checkbox"/> HIV Results |
| <input type="checkbox"/> Psychiatric/Psychological (Mental Health) | <input type="checkbox"/> Other (specify) | |

Please send the above information to: _____

Date of Request: _____

Patient Name: _____

Social Security # _____ - _____ - _____ **DOB:** _____

Signature: _____

Witness: _____ / _____
Signature **Print Name**

