MEDICAL CONCIERGE CARE

MEDICAL RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

H. Phone: _____ Cell: _____ SS#: _____

I hereby authorize and request _____
to release medical information concerning my medical care to Dr. Allen T. Schwartz, for the purpose of

_____.
(Specific purpose of disclosure of record)

Forward To: DR. ALLEN T. SCHWARTZ, C/O MEDICAL CONCIERGE CARE
785 HWY. 466, LADY LAKE, FLORIDA, 32159,
Office: 352-775-6428, Fax: 352-633-1614.

The type and amount of information to be disclosed is as follows: (Specify dates where appropriate).

_____Last 3 Progress Notes
_____Most Recent Laboratory Tests
_____Bone Density
_____Most Recent Radio-Diagnostics Test
_____Problem List / Medication List
_____Other

If more than 25 pages please mail. Thank You.

I understand that the information may include the release of information concerning HIV testing or treatment of AIDS or AIDS related conditions, drug or alcohol abuse (or related conditions), and mental health conditions.

I understand the use or disclosure of my individual health information, as described above. I understand that this authorization will expire, without my express revocation, either one (1) year from the date of signing, or if I am a minor, on the date I become an adult according to state law, which ever occurs first. I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. I understand that this authorization is revocable, upon written notice to the office where the original authorization is retained.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulation, and that it may be re-disclosed by the recipient.

The facility, its employees, officers, and physicians are hereby released from any liability for the disclosure of the above information to the extent indicated and authorized therein.

Patient Signature _____ Date _____

Signature of Parent or Legal Representative _____

785 Highway 466, Lady Lake, Florida, 32159 Office: 352-775-6428 ** Fax: 352-633-1614
Email: mail@mccvillages.com Web: www.mccvillages.com