324 E. Par Street Suite 200
Orlando, FL 32804
407-843-2020

RAMIREZ & POULOS
MD | PA

809 E. Oak Street Suite 202
Kissimmee, FL 34744
407-847-2020

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date: _____ Date of Birth _____

I authorize **Ramirez and Poulos, M.D. P.A.**

Provide dates, diagnosis, treatment or any other indications of the specific information you desire:

_____

_____

_____

_____

**Release Records to:** Physician or Institution_____

Address: _____

City, State & Zip Code_____

This authorization will remain in effect for six months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the patient at any time.

This information is CONFIDENTIAL. Redisclosure of this information is strictly prohibited by law without the written permission of the person to whom it pertains.

The undersigned hereby releases the above-mentioned physician or institution from any liability which may arise from release and/or examination of the information indicated above. I understand that there may be a charge for copies and record review and that such charges must be paid prior to review or release of copies.

**SIGNATURE:**_____

SPECIAL CONSENT: I also authorize the release of information regarding HIV, AIDS, or AIDS related status to the person/institution named above