ANASTASIA FAMILY CARE
AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

Patient Name: _____
Last First Initial

Address: _____
Street City State Zip

Phone: ( ) _____ DOB: _____ SS# _____

I authorize _____
NAME of PREVIOUS PROVIDER ADDRESS PHONE
to release medical information from my medical records to:

ANASTASIA FAMILY CARE
103 ANASTASIA BLVD
ST. AUGUSTINE, FL 32080 **PHONE (904) 825-4747**
FAX (904) 825-2885

For the purpose of review/examination and further authorize you to provide such copies thereof as many be requested. The foregoing is subject to such limitations as indicated below:

☐ Entire Record

☐ Specific Information: _____

☐ Old Records from Previous Physicians

I give special permission to release any information regarding: (initial on line(s) below that you grant us permission to release the information to the above)

_____ Substance Abuse _____ Psychiatric/Mental Health Info. _____ HIV Info.

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken to reliance thereon.

Reason for Request: _____

Signed: _____
(IF NOT PATIENT, STATE RELATIONSHIP)

Witness: _____

FOR OFFICE USE ONLY

Received: _____ Completed: _____
Fee Paid _____
Completed: _____ Amount Due/Billed: _____

Disclosure consisted of: _____