CAPPLEMAN MEDICAL GROUP
436 N. Dillard St.
Winter Garden Fl, 34787

John M. Cappleman M.D.
Karen Jones A.R.N.P.

Medical Records Release

Date:

I, _____

Print Name

Hereby Author ize _____

Fax# _____ **Phone #** _____

Address: _____

To release records to _____

Fax # _____ **Phone #** _____

DOB: _____ SS# _____

Labs ____ Office Notes ____ Diagnosis Reports ____ Other _____

I understand that specific information to be released may include AIDS or HIV, Alcohol and/ or Drug Abuse and Mental Health. I understand that if I request copies of records for a member of my family or myself, a review of this information with my physician or other healthcare provider may be necessary. I understand that if my physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein. Unless otherwise indicated, the authorization will expire ninety (90) days from the date of this signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that the action has been taken in reliance on this authorization for the purpose stated above. I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____

Signature of patient/ Legal Representative Relationship to Patient Date

Witness

_____