

JOSE A. LOPEZ-CINTRON, MD, LLC

Consent For Release of Confidential Information

Patient's Name _____ DOB _____

I authorize and hereby request that a copy of my medical records be released as follows:

INFORMATION TO BE RELEASED TO:

JOSE A. LOPEZ-CINTRON, MD, LLC

Name

1067 Town Center Drive

Address

Orange City, FL 32763

City

State

Zip

INFORMATION TO BE RELEASED FROM:

Name

Address

City

State

Zip

- This release is to cover ALL records contained in my file.
 This release is to cover the following specific records:

You must make a request in writing to obtain access to your medical information. You may also request access by sending us a letter to our office address. If you request copies, we will charge you \$0._____ for each page, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us at 1067 Town Center Drive, Orange City, FL 32763 or by telephone at 386-774-9890.

The purpose of this request is for continued medical care.

I understand that the information contained in my medical records may include records pertaining to diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, including alcoholism and/or drug addiction. May also contain information regarding test results for AIDS, HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.

Signature of Patient, Parent, or Legal Guardian

Date

Witness

Date