inclusive care group

# Authorization for Release of Medical Records

Name of patient

Date of birth

Other names

Purpose of authorization

Date of request

I hereby authorize my previous/consultant physician to furnish information from medical records, or reporduce the record in whole or in part and submit copies to Inclusive Care Group.

Practice of Dr. Antonio Luis.
8700 66th Street North, Suite 204 Pinellas Park, FL 33781
Phone: 727-753-7787 Fax: 833-471-3023

| Information requested | Medical record for: | | If checked, signature of patient |
|---|---|---|---|
| | HIV/Aids dx and tx | | |
| | Pschiatric dx and tx | | |
| | Substance abuse tx | | |

This will release Inclusive Care Group and Dr. Antronio Luis of all legla liability that may rise as a result of the above information.

Signature of patient

Date

Printed Name

Witness signature