Medical Records Release Form

By signing this form, I authorize you to release to confidential health information in the form of a copy of my medical records, summary, or narrative of protected health information *to:*

Nostalgia Family Medicine and Wellness Center
Brandon Fletcher, MD
771 Ciara Creek Cove
Longwood, Florida, 32750
www.nostalgiamed.com
Phone: 407.543.1270
Fax: 407.813.1311

The Information you may release subject to this signed release is as follows:

___Complete Records	**___History & Physical**	**___Progress Notes**
___Care Plan	**___Labs Reports**	**___Radiology Reports**
___Pathology Reports	**___Treatment Record**	**___Operative Reports**
___Hospital Records	**___Medication Record**	**___Other _____**

Dates:_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□Yes □No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□Yes □No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

RECORDS to be released from:

Physician/Office:_____
Hospital:_____
Address:_____
Phone#:_____**Fax/Email:**_____

Patient Name:_____
Date of Birth:_____**SSN:**_____
Address:_____

Signature of Patient or Representative:_____
Date:_____