917 Rinehart Rd #2061 Lake Mary, Fl 32761

Phone 800-652-0592 Fax 800-652-1625

Medical Records Release Form

Patients Name: _____ Date of Birth: _____/____/_____

Dates of treatment requested: ALL or From:_____To:_____

Release of Information: Doctors information

From: _____ To: BudDocs and its physicians

Address: _____ Fax: 1-800-652-1625

Phone or fax: _____ Email: info@buddocs.org

I_____, voluntarily and without coercion authorize the party above to obtain my health information indicated that is contained in my medical records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnosis.

This Release of Information will remain in effect until terminated by me in writing.

Notice of Privacy Practices: I acknowledge that I have reviewed the Notice of Privacy Practice available online at buddocs.org/terms.

Signature: _____ Printed name: _____

Date Signed: _____ Relationship: _____

If other than the patients signature, a copy of legal paperwork verifying patient's personal representative must accompany the request. (i.e. Court appointment guardian, durable power of attorney for healthcare).