917 Rinehart Rd #2061 Lake Mary, Fl 32746
Phone 800-652-0592 Fax 800-652-1625

Medical Records Release Form

Patient Name: _____ Date of Birth:_____ /_____ /_____

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

Release of Information: Your Doctors information

From: _____ To: BudDocs and its physicians

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

Phone: _____ 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.

This release shall be in compliance with federal regulations (42 CFR Part 2) and with all applicable state and local laws, rules and regulations.

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 patient's 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).