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## **Authorization to Obtain/ Release Medical Records**

Patient Name:		Date of Birth:	
Telephone #:			
Purpose of Release:			
I hereby authorize North Po	int Physicians, LLC to:	Obtain from Release to	
Name:			
Address:			
Telephone #:		Fax #:	
during the following time pe	eriod:	cords of any treatment or examination rendered to	me
<u> </u>	ve (12) months, <b>OR</b> e period to _		
information, Florida Statute	397.501, and 396.112 Di	rmation under Florida Statute 394.459 (9) Psychiatr Orug and/or Alcohol Abuse Information, and Florida ency Virus test result (HIV testing, AIDS, and related	Statute
revoke it in writing. I hereby	release the above name	nins in effect for a period of twelve (12) months or u ed medical facility, practitioner, and its employees f of this information as I have directed.	
Signature:(Patient,		Date:	
(Patient,	Parent if minor, or Legal guardian)		
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