DIVERSE MEDICAL PROFESSIONALS

CONSENT FOR RELEASE

PURPOSE OR NEED OF RELEASE OF INFORMATION/MEDICAL RECORDS

TO: _____

PHONE: _____

FAX: _____

ATTN: _____

FROM: _____

Diverse Medical Professionals
1200 S Federal HWY Suite 302 Boynton Beach, FL 33435
Phone: 561-509-9382

Fax: 561-509-9362

WHAT REPORTS ARE TO BE RELEASED:

- MRI Report(s) / CT Scan Report(s) / -Xray Report(s)
- Pharmacy Records
- Lab Results
- Initial Medical Examination and/or Progress Notes
- Hospital Record(s)
- Discharge Summary

The above-mentioned has information, including diagnostics and record of any examination or treatment rendered to me during the period _____to _____ include, any federal and state protected examination under Florida Statue 394.459(9) Psychiatric information, Florida Statue 397.053 and 396.112, drug and/or alcohol abuse information, and Florida Statue 381.609(2) Human immunodeficiency Virus test results and related conditions.

I understand by approving the release of information in the form of a fax, confidentiality cannot be assured. I accept the risk that confidentiality may be breached when faxing information. I hereby release Diverse Medical Care, LLC and its employees from any and all liability that may arise from this release of information.

Patient's Name: _____ **DOB:** _____

Patient's Signature: _____ **Date:** _____

This information may be revoked at any time upon written notification by the patient, but revocation has no effect on any action previously taken.