Dr. Cheri McCue Family Practice

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION	
Patient Name:	DOB:
Address:	Tel:
City, State Zip:	Social Security Number:

I request and authorize Dr. Cheri McCue Family Practice to disclose all protected information for the purpose of review and evaluation as selected below:

The following information is requested and may be released:		
O **All Medical Records**	O Medication List	O Radiology Reports
O Pharmacy/Prescription Records	O Billing Records	O Immunization Records
O Lab Reports	O Other: _____	

Please release records from the following dates: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases , acquired immunodeficiency syndrome (AIDS), or (HIV), and drug abuse.
I authorize the release and disclosure of this type of information. _____ (initial)

Release the Information to:		From:
Name:	**Family Practice**	Name:
Address:	**Dr.Cheri McCue**	Address:
City, State, Zip:	**(863) 991-2819 Fax (863) 446-0639**	City, State, Zip:
Phone	**5 Ryant Boulevard**	Phone
	Sebring Florida 33870	

The purpose and the use and/or disclosure is: _____
I understand that:

a) I have a right to revoke this authorization in writing at any time, except to extent information has been release in reliance upon this authorization.
b) The information released in response to this authorization may be re-disclosed to other parties
c) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimilie, copy, or photocopy of the authorizationshall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of excecution at which time this authorization expires.

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION	
_____ Signature of Patient/Legal Authorized Representative	_____ Date
_____ Printed Name and Relationship of Legally Authorized Representative	_____ Date
_____ Witness Signature	_____ Date

***** PLEASE EMAIL ALL RECORDS OVER 25 PAGES TO: drcmccue.roxanne@gmail.com**