Josee Arcand M.D.

21 Suntree Pl, Ste 102, Melbourne, Florida, 32940

PH: 321-255-7334 FX: 321-255-7336
FX: 321-234-9222

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following provider(s) and its physicians, employees and agents to release or disclose to ARCAND FAMILY PRACTICE (AFP) and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records.

HEALTHCARE PROVIDER **Address** **PHONE OR FAX NUMBER**

_____

_____

_____

Release records to:

Arcand Family Practice
21 Suntree Pl, Ste 102
Melbourne, fl, 32940

Patients Name: _____ **Date Of Birth:** _____

I understand that I may revoke this authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above named healthcare provider(s) or its employees or agents. Should I desire to revoke this authorization, I must send written notice to the healthcare provider(s)

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization does not limit the above-named healthcare provider(s), agents or employees ability to use or disclose my information for treatment, payment, or healthcare operations or as otherwise permitted by law.

I understand and acknowledge that I am responsible for all costs associated with the provisions of the information described herein.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____

THIS AUTHORIZATION WILL EXPIRE TWO YEARS AFTER THE DATE OF SIGNATURE. A PHOTOCOPY OF THIS IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.