PLEASE NOTE: This form has interactive fields.
You may type your information directly into most fields; however it CANNOT be submitted electronically. Once you have completed the form it should be printed, then signed.

Baldwin Park Family Practice, P.A.
Promoting Healthy Lifestyles
1040 Woodcock Road, Suite 200
Orlando, Florida 32803
Tel: 407-898-4550
Fax: 407-898-4842
Email: info@baldwinparkfp.com

Authorization To Obtain, Release Or Review Protected Health Information

INSTRUCTIONS: Forms must be filled out COMPLETELY in order to be processed: **ALL fields are required.** Records will be processed in **approximately 10 business days** from submission of a completed form.

I, _____ hereby authorize Baldwin Park Family Practice to
Patient/Legal Representative

release copies of protected health information of: _____
Print Patient's Name

FROM:
Baldwin Park Family Practice, P.A., 1040 Woodcock Road, Suite 200, Orlando, Florida 32803
PH: (407) 898-4550 | FAX: (407) 898-4842

For Dates of Services From: _____ To: _____
Format: MM/DD/YYYY Format: MM/DD/YYYY

SEND MY RECORDS TO: Please **TYPE or WRITE Legibly** in the box below, it will be used as the address label

Address Label:
Facility Name & Address ------->

Recipient's

Phone: _____

Fax: _____

Email: _____

Please check ALL items you would like released:

☐ All Chart / Visit Notes ☐ Consultations
☐ Labs ☐ Radiology ☐ Other *(Specify)* _____

Additionally, please INITIAL each/all applicable items:

_____ Mental Health _____ HIV Testing _____ Drug and/or Alcohol _____ AIDS Information

_____ _____
Date of Birth (Format: MM/DD/YYYY) Social Security Number (No Dashes)

_____
Address City State Zip

_____ _____
Patient/Legal Representative/ Parent Signature Date (Format: MM/DD/YYYY)

_____
Witness

Print Your Form