Orlando Internal Medicine

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Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

I request and authorize you to release the records on file from Orlando Internal Medicine to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

This request and authorization applies to:

- ☐ Labs, Imaging, Consult Notes, Discharge instructions, Medication List, etc.
- ☐ All medical records (*up to and including the information outlined below*)
- ☐ Specific healthcare related information (*please specify*): _____

  _____
- ☐ Information related to Sexually Transmitted Diseases *(as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.)*
- ☐ Any records regarding drug, alcohol, or mental health treatment.
- ☐ Other: _____

Patient Signature: _____ Date: _____

You must request in writing for this medical records request to become null and void.

Ravi Akella, MD **Nicole Reda, APRN**