Erica L. O'Donnell D.O., P.A.

Authorization To Disclose Medical Records

Name:_____ DOB:_____ Phone:_____

Please Obtain Information From:		Please Send Information To:	
Erica L. O'Donnell D.O., P.A.- Dr. O'Donnell			
Name of Provider/Clinic/Organization		Name of Provider/Clinic/Organization	
1400 Hand Ave Suite K			
Street Address		Street Address	
Ormond Beach, FL 32174			
City, State, Zip Code		City, State, Zip Code	
(386) 671-2771	(386) 671-6458	( )	( )
Phone Number	Fax Number	Phone Number	Fax Number

Primary Physician
Dr. Erica L. O'Donnell

I AUTHORIZE the following information to be forwarded:

Records From:_____ To:_____

□ Lab Results □ STD Record □ TB Test

□ Imaging Reports □ Psychiatric/Mental Health □ Other:_____

□ Office Visits □ Alcohol/Substance Use _____

□Immunization Record □ HIV Record _____

REASON for Disclosure of Health Information:

□ Changing Primary Physician □ Job □ Other:_____

□ Continuing Care □ School _____

□ Legal □ _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization in writing.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ _____ _____

Patient Signature (Parent or Legal Representative) Relationship/Authority Date

□ Pick Up Records □ Fax Records □ Mail Records