RECORD RELEASE AUTHORITY

TO: (Clinic/Doctor's Name) _____

_____

I, (Patient's Name) _____ hereby request that

you release to

CONVENIENT MEDICAL & HEALTH SERVICES INC.

507 S. MACDILL AVE., TAMPA FL 33609

Telephone: (813) 350 9398 **Fax: (813) 414 9181**

The informationn to be disclosed is: (check all that apply)

_____ Office Note _____ X-Ray/CT Scan/MRI etc.

_____ Lab Report _____ All Records _____ Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or Hepatitis. It may also include information about behavior or mental health service, and treatment for alcohol and drug use

I have carefully read and understand the above statement and do herein expressly and voluntarily consent to disclosure of the above information about, or medical records for my medical condition to those persons or agencies above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of individually Identifiable Health Information (45 C.F.R Part 164), A photocopy of the authorization shall have the same effect as the original

_____ _____

Patient's Date of Birth Signature of Patient

_____ _____

Date Please print name signed above