MID-FLORIDA PSYCHIATRY CENTER
P.O Box # 1020, Davenport, FL 33837
Phone: (863) 419-7645, Fax (863) 419-7655
Email: Contact@telepsychlive.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____
I HEREBY Authorize the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/ or obtain any and all the information it possesses relating to my evaluation(s), treatment and illness (es)including the psychiatric and psychological information which may be part of the medical records to/from:

Name: _____
(Name of Physician, psychotherapist, legal representative/ agency, or facility)

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

IMORTANT NOTE: If the information being released and/or obtained contains alcohol and/or drug abuse/ dependence diagnosis, treatment, rehabilitation, or education for prevention, or content related to HIV status, AIDS diagnosis or treatment, you must give further consent as follows:

I give my consent for the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/or obtain information from my records concerning my alcohol and/or drug abuse/dependence in conjunction with the above.

I give my consent for the Mid- Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/or obtain information from my records concerning my HIV status, AIDS in conjunction with the above.

_____ Date: _____
Signature of patient or legal guardian

☐ Check to accept or authorize instead of signature

Image: Drivers ID for proof of the person.