LIVE WELL MEDICAL CENTERS ORLANDO, LLC
7051 DR. PHILLIPS BLVD. SUITE 3
ORLANDO, FL 32819

AUTHORIZATION TO RELEASE PERSONAL HEALTHCARE INFORMATION TO SPECIFIC INDIVIDUALS*

Please check one of the following statements

I DO authorize the release of my personal healthcare information to __________________________ (print name of specific individual and check relation).

_____ spouse
_____ relative
_____ other i.e. friend or significant other

I DO NOT authorize the release of my personal healthcare information to any individual _______ (please initial).

*Please note that if you choose not to disclose personal healthcare information to any individual it is possible that your healthcare may be delayed if we are unable to contact you directly. You may change or withdraw your authorization at any time in writing.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

____
Date