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

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I authorize any physician, medical professional or other medical or healthcare institution, insurance or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give any and all such information to Live Well Medical Centers Orlando, LLC, its representative and any consumer reporting agency acting on its behalf.

I UNDERSTAND the information obtained by use of the authorization will be used by Live Well Medical Centers Orlando, LLC to determine eligibility for insurance.
I KNOW that I am entitled to receive copy of this authorization upon request.
I AGREE that a photocopy of this authorization shall be as valid as the original.
I ACKNOWLEDGE receipt of the Notice of Privacy Practices.
I KNOW that I may withdraw this authorization in writing.
I AGREE this authorization will be valid for one year from the date below.
I AGREE to the release of any psychiatric information that may be in my record_____ (please initial).
I AGREE to the release of HIV information that may be in my record_____ (please initial).
I AGREE to the release of any drug and/or alcohol related information that may be in my record_____ (please initial).

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date