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

FAX PRIVACY WAIVER FORM

I understand that my medical records may be transmitted by fax and may be received in error by a third party. In the event that this should occur I absolve Live Well Medical Centers Orlando, LLC of all liability. I give consent to fax my records for the purposes of treatment, payment for treatment, administrative purposes, and/or other healthcare operations. However, I may withdraw this consent at any time in writing.

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Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date