

**SOUTHWEST INTERNAL MEDICINE SPECIALISTS
DIPLOMATS, AMERICAN BOARD OF INTERNAL MEDICINE**

M.J. GALCERAN, M.D APARNA HERNANDEZ, M.D RICARDO A. PEREZ, M.D.
SARAH ARMY, PA-C REBEKAH WAGNER, PA-C

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize _____

(Phone and fax number)

To release medical psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorders information or any other records of sensitive nature to:

Dr. Galceran, Dr. Hernandez, Dr. Perez, Sarah Army, PA-C and Rebekah Wagner, PA-C
7301 Stonerock Circle, Suite 1
Orlando, FL 32819
Phone: (407) 345-0005 Fax: (407) 352-8585

For the purpose of _____
(Specific purposes for disclosure of records)

The specific reports to be disclosed shall include _____

I understand that this consent is revocable upon written notice to Drs. Galceran, Dr. Hernandez, Dr. Perez, Sarah Army, PA-C and Rebekah Wagner, PA-C except to the extent that the action has already been taken on this authorization. This authorization shall remain in force until _____ or for a reasonable time to accomplish the purpose for which it is given. Alcohol and drug abuse information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further, disclosure without specific written specific written authorization of the undersigned, or as otherwise permitted by such regulations.

(Date of authorization)

(Patient signature in full)

(Date of birth)

(Parent, legal guardian, power of attorney)