JUAN C. YORDAN, MD PA
FAMILY PRACTICE
929 North US Highway 441/27 Suite 102 Lady Lake, Florida 32159
PHONE 352-633-0473 ● FAX 352-775-9562

Request for Medical Records

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my records, summary or narrative of my protected health information, to the physician/person/facility/entity Juan C. Yordan, MD. I understand that expiration date of this authorization is one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal Privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand I have the right to receive a copy of this form after I have signed it. I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval photocopying of records and/or supervising inspection of medical records.

Patient Name: _____ **Date of Birth:** _____

Purpose of Disclosure: ( ) Continuing Care ( ) Other

- ✓ The information you may release subject to this signed release form is as follows:

__: Office visit notes __: Stress Test

__: Labs (last 2 years) __: Echocardiogram

__: Colonoscopy/ Endoscopy Report __: Radiology (X-ray, CT Scans)

__: Specify: _____

I specifically authorize the release of information relating to:
__: Substance Abuse (Including alcohol/drug use)
__: Behavioral Health
__: HIV related information (AIDS related testing)
__: Communicable Disease

Release my protected health information to the following physician/ facility/ entity and/or those directly associated in my medical care to the office of Juan C. Yordan, M.D. Lady Lake, FL.

Patient/ Legal Guardian Signature: _____

Date: _____