HEALTH RELEASE FORM

NAME _____ Date of Birth_____

SENDING FOR RECORDS: *I permit the release my own health and medical information TO Florence Bamgbose, NP. and GenerationSpan Healthcare (GSHC) providers FROM*_____
        (name of doctor, hospital, nurse practitioner or other health care provider).

I permit the release of (check off one or more):

_____ all tests from the last year   _____ office visit notes for the last year

_____ history and physical   _____ admission and discharge summary

_____ HIV /AIDS information and testing _____ Mental Health records

_____ ALL records.

SIGNED _____

SENDING RECORDS FROM GSHC: *I permit the release my own health and medical information FROM GenerationSpan Healthcare, Florence Bamgbose, NP, and others TO* _____
        (name of doctor, hospital, nurse practitioner or other health care provider).

I permit the release of (check off one or more):
_____ all tests from the last year   _____ office visit notes for the last year

_____ history and physical   _____ Mental Health records

_____ HIV /AIDS information and testing _____ ALL records

SIGNED _____

PERSONAL COMMUNICATION: *I request Florence Bamgbose, NP and GenerationSpan Healthcare providers to be allowed to talk with and otherwise communicate with*

_____
        (friend, relative, counselor, other practitioner, etc.)

GET HOSPITAL RECORDS IF NEEDED IN FUTURE: *In case I am treated at the hospital sometime in the future (either Tallahassee Memorial or Capital Regional Medical Center) at the Emergency Room or admitted to the hospital, I want Florence Bamgbose, NP and GenerationSpan Healthcare providers to be able to get my records including Admission and Discharge Summaries, and all tests done.*
SIGNED_____

I want this permission to expire on _____ (date that it will no longer be good)