

# RIDGE MEDICAL ASSOCIATES, LLC

405 South 11th Street  
Lake Wales, FL 33853  
Phone (863) 679-8000  
Fax (863) 679-8008

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

I hereby authorize the release of information from: (please check one box)

\_\_\_\_\_  
Name of sending medical facility

OR

Sunil Nihalani, MD / Preeti Harchandani, MD  
Ridge Medical Associates, LLC  
405 South Eleventh Street  
Lake Wales, FL 33853

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone number Fax number

This information may be released to:

\_\_\_\_\_  
Name of sending medical facility

OR

Sunil Nihalani, MD / Preeti Harchandani, MD  
Ridge Medical Associates, LLC  
405 South Eleventh Street  
Lake Wales, FL 33853

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone number Fax number

Records from time period: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Purpose of disclosure: \_\_\_\_\_

Information to be released: \_\_\_\_\_ In asking for the entire record to be released, I understand that will include sexually transmitted disease records, HIV/AIDS records, drug and alcohol records and psychiatric records.

I understand that this authorization shall be valid for 90 days from the date given below. I may revoke it in writing at any time except to the extent that action has already been taken. A copy shall be as valid as the original.

I understand that a fee, which will be estimated in advance of duplication, may be charged.

I release this medical facility from all liability which may result from the release of information authorized by this consent.

I have read this authorization form and voluntarily and knowingly sign such authorization.

\_\_\_\_\_  
Patient or Authorized Representative (relationship to patient)

\_\_\_\_\_  
Date