TotalWell Health Clinic
1425 Tuskawilla Road Suite 221, Winter Springs, Fl 32708
Phone Number: 407-775-5315
Email: totalwellhealth@gmail.com
Website: **www.totalwellhealth.com**

CONSENT TO OBTAIN MEDICAL RECORDS FROM PREVIOUS HEALTHCARE PROVIDERS

Patient Information
(Please complete all sections to avoid delays in processing your request)

- **Full Name**: _____
- **Date of Birth**: _____
- **Phone Number**: _____
- **Email Address**: _____
- **Mailing Address**: _____

PREVIOUS HEALTHCARE PROVIDER INFORMATION

(Please provide details of the previous provider(s) from whom you are authorizing us to obtain your records)

- **Provider's Name**: _____
- **Practice Name**: _____
- **Address**: _____

- **Phone Number**: _____
- **Fax Number**: _____
- **Email Address** (if applicable): _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby consent and authorize **TotalWell Health Clinic** to obtain my medical records from the healthcare provider(s) listed above. These records may include but are not limited to:

- Medical history and physical exams
- Diagnostic test results (e.g., labs, imaging)
- Treatment/progress notes
- Medications and prescriptions
- Immunization records
- Other medical records (please specify): _____

I understand that this consent is being provided for the purpose of continuity of care and evaluation in relation to my treatment at **TotalWell Health Clinic**.

AUTHORIZATION

I understand that:

- I am authorizing the release of my medical records to **TotalWell Health Clinic** from the healthcare provider(s) listed above.
- This consent is voluntary, and I have the right to withdraw or revoke my consent at any time by submitting a written request to **TotalWell Health Clinic**.
- I may request a copy of the records being requested for my own records.
- The information released may contain sensitive information, including mental health, substance use, HIV-related treatment, or other protected health information, unless otherwise restricted.
- I understand that the provider may charge a reasonable fee for the copying and transfer of my medical records as allowed by Florida law.
- I understand that once my medical records are released to **TotalWell Health Clinic**, they may no longer be protected by HIPAA privacy regulations, depending on who receives or accesses the information.

EXPIRATION OF CONSENT

This consent will remain valid until the medical records are received or until the purpose of the request is fulfilled, but in no case will this consent remain valid for more than one year from the date of signing.

SIGNATURE AND ACKNOWLEDGEMENT

- **Patient's Signature**: _____
- **Date**: _____
- **If applicable, Legal Representative/Guardian Name**: _____
- **Relationship to Patient**: _____
- **Signature of Legal Representative/Guardian**: _____
- **Date**: _____

FOR OFFICE USE ONLY

- **Request Received By**: _____
- **Date of Request**: _____
- **Records Received From**: _____
- **Date Records Received**: _____
- **Processed By**: _____