Donna B. Murray, DNP

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P: 561.323.7979
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Murray & Associates Family Healthcare

PERSONAL HEALTH INFORMATION CONSENT

Facility Name and Address to Obtain Records:

_____

_____

Phone : _____
Fax : _____

Please send my health information to:

MURRAY & ASSOCIATES FAMILY HEALTHCARE
3319 S State Road 7, Suite 106
Wellington, Florida 33449
Fax: 561.323.7977
Email: dmurray@donnadoc.com

Reason for Request or Release: _____

Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

(Print) Name: _____ DOB: _____

Patient signature: _____Date: _____