

CONSENT TO RELEASE INFORMATION

Florida's Blood Centers, Inc.
8669 Commodity Circle
Orlando, FL 32819

I hereby authorize Florida's Blood Centers, Inc. (FBC) to release any and all information including HIV results in the files maintained by FBC relating to me. In connection with the foregoing, I hereby release and agree to hold harmless FBC from and against any and all use or misuse of such information by any party to whom the same may be released. I further acknowledge that I have been advised to seek the advice of my own physician in order to evaluate these findings.

Name: _____
(Last) (First) (Middle)

Identification #: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

ID Verified: Photo ID Verbal Verification: Street Address DOB Case# ABA# Phone Consent

Send Records via (check all that apply): Mail E-MAIL Fax

RELEASE RECORDS TO:	
Name:	_____ <i>(Please Print or Type)</i>
Address:	_____ _____
Email:	_____
Telephone:	_____ <i>(Include Area Code)</i>
Fax:	_____ <i>(Include Area Code)</i>