

# 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.

Name: \_\_\_\_\_  
*(Last)* *(First)* *(Middle)*

Last 4-Digits SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

ID Verified: Photo ID  Verbal Verification: Street Address  DOB  Last 4-Digits SSN

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

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