Authorization for Release of Information

Patient name:_____

ID#_____ D.O.B._____

I hereby authorize _____

to release my medical records to:

Name:_____

Address:_____

City/State/Zip:_____

Relationship to Patient: Physician____ Attorney_____ Legal Guardian____Ins.Company____

This authorization is for all dates of service unless otherwise specified below.
This authorization only for these date(s) of treatment: from _____to_____.

Patient Signature:_____

I hereby authorize _____, Medical Record Dept., to Release Medical Records pertaining to Psychiatric, Mental Health, Alcohol Abuse and/or Drug Abuse including treatment:

Patient Signature:_____ Date:_____

I hereby authorize _____, Medical Record Dept., to Release Medical Records pertaining to AIDS and/or HIV positive including testing, diagnosis and/or treatment:

Patient Signature:_____ Date:_____

By authorizing the release of the above mentioned records, I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I hereby release the above facility and it's employees from any liability that may arise as a result of the use of the information contained in the records released.

I also understand that I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.

I agree to accept responsibility for payment of any Fee charged for the information requested. I understand that fees charged are within the allowable by Florida Law.

Patient Signature:_____Date:_____

Witness Signature:_____ Date:_____