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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Re: ______________________________________ Date of Birth: _________________________
Print Patient's Name

SSN: ________________________________

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any re-disclosure is strictly prohibited without the written permission of the patient/legal representative identified below.

I authorize: ____
Name of the Facility/Person Holding the Information

____
Address

____
City, State, and Zip Code

____
Fax

To release from my medical records the following: **(please initial next to the applicable area)**

________ General medical information. (Florida statue 395.97)

________ Psychiatric/psychological information, alcohol and/or drug abuse information. (Florida statue 394.459 and Federal Regulation 42CFA, Part II)

________ HIV test and information pertaining to these tests, or to treatment in connection with these test results.

To: ____
Name of the Facility/Person to Receive the Information

____
Address

____
City, State, and Zip Code

____
Fax

For the purpose of: ____

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). I also understand that this authorization will remain in effect for ninety (90) days unless I specify an earlier expiration date here:________________________________(date).

Patient/Legal Representative's Signature	Date
Legal Representative's Relationship to the Patient	Signature of Witness
Print Name of Person Requesting Records	*Phone Number of Person Requesting Records*