



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____ Daytime Phone: _____
Social Security Number: _____ Date of Birth: _____

I authorize _____
Address: _____ City: _____ State: _____ Zip: _____
to release general medical information to the physician/facility indicated below, pursuant to Florida Statute 456.057, as well as specific, applicable information as noted below, from my medical record.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. (MUST BE INITIALED)

- _____ Psychiatric/psychological information as protected by Florida Statute 455.667[4]
- _____ Drug/alcohol information as protected by Florida Statute 397.501[1]
- _____ HIV/AIDS information as protected by Florida Statute 381.04(3)(f)
- _____ Sexually transmitted diseases as protected by Florida Statute 384.29

Release to: Name: _____
Address: _____ City: _____ State: _____ Zip: _____

The information is to be: Mailed Picked up - Date: _____ Time: _____ AM PM
 Faxed Fax number: _____

The information is subject to the limitations as listed below and is for the purpose of:
 Personal Treatment (Continued Care) Payment Healthcare Operations
 Physician Appointment (Date/Time) _____ Other: _____

Specific information to be released: _____
Specific dates to be released: _____

Consent to Minors: Minors are permitted to consent to medical care and treatment in the following situation. Thus the parents are not entitled to the minor's medical information without written consent of the minor, a valid subpoena or court order.

1. A minor who is, or has been, married.
2. An unwed pregnant minor consenting to the medical or surgical care or services relating to the pregnancy.
3. An unwed minor mother consenting to the medical or surgical care or services of her child.
4. A minor who is receiving contraceptive information or services.
5. A minor with a court order removing the disability of nonage.
6. A minor seeking voluntary treatment, examination, counseling, and/or intervention services relating to psychiatric/psychological, drug and/or alcohol, HIV/AIDS, and/or sexually transmitted diseases.

Information released by the above may not be re-disclosed without expressed authorization by the patient. This authorization will be valid for ninety (90) days after the date of the patient's signature as it appears below.

I understand I have the right to refuse this authorization and that with my signature, the facility named above is released from all legal liability that may arise from the released information requested. I understand that I have the right to revoke this authorization, in writing, except to the extent that action(s) have been taken as outlined by this authorization.

Patient Signature: _____ Date: _____

If the legal representative, sign below and state relationship to the patient. Attach a copy of the document of authority if not present in the patient's medical record.

Legal representative _____ Date: _____

If the patient is a minor or is unable to sign, include title/legal status of the representative.

Signature/Title: _____ Date: _____

Witness signature _____ Date: _____