AUTHORIZATION FOR

RELEASE OF CONFIDENTIAL INFORMATION

Regarding:_____
Print Patient's Name

_____ _____
Social Security # Date of Birth

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

I authorize _____
(Name of previous physician holding information)

_____
(Address)

_____
(City/State/Zip Code)

to release written general medical information from my medical record (Fla Statute 395.017) as well as psychiatric/psychological information, alcohol and/or drug abuse information (Fla Statute 394.459 and Fed. Reg. 42CFA, Part II), Human Immunodeficiency Virus (HIV) tests and other information (Fla Statute 381.004) pertaining to these tests or to treatment in connection with these test results to:

_____
(Name of facility/person to receive the information)

_____
(Address)

_____
(City/State/Zip Code)

_____ _____
(Patient/Client/Legal Representative's Signature) (Date)

_____
(Signature of Witness)

This facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

2/21/01 version