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I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, and by giving written notice to Flagel Pediatric & Family Medicine. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) __ _____

DATE OF BIRTH_____ LAST 4 DIGITS OF SOCIAL SECURITY #_____TELEPHONE #_____

PROVIDER (WHO IS TO DISCLOSE INFORMATION)

NAME _____

STREET ADDRESS_____

CITY, STATE, ZIP_____

TELEPHONE #_____FAX #_____

RECIPIENT (WHO IS TO RECEIVE INFORMATION)

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North Port, FL 34289

REASON FOR RELEASE OF INFORMATION _____

INFORMATION TO BE RELEASED _____ ****IF MORE THAN 20 PAGES, Please MAIL RECORDS****

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:
(CHECK ALL THAT APPLY)

MENTAL HEALTH ____
HIV-RELATED INFORMATION (INCLUDING AIDS AND RELATED TESTING) ___
SUBSTANCE ABUSE TREATMENT (ALCOHOL/DRUG) ___

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE_____DATE:_____
RELATIONSHIP TO PATIENT, IF SIGNED BY LEGAL REPRESENTATIVE:_____

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