AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize you to release and furnish:

To:

From:

ALL MEDICAL RECQRDS, including but not limited to x-rays, office records, or other documents of any description or kind from any physicians, hospitals or other health care providers including billing information and including not only general medical records but as well, records of psychiatric, psychologic, alcohol or drug use, records of human immuno-deficiency virus (HIV or AIDS) testing, diagnosis, treatment, and any related information; and any and all health records that may originate with your institution, or yourself, or be supplied to you by other institutions, physicians, hospitals or health care providers; in accordance with Florida Statutes 394-459, 395-004(3)(t)(2) and in accordance with Florida Statutes 90.503,458.16 and 450.21

I understand that these records may contain information not strictly in nature I

understand that I have the right to refuse this authorization

This authorization remains valid until revoked in writing. A photocopy of this authorization is as valid as the original.

Patient's signature:_____ _ _

Patient's name (print):_____

Parent or Guardian signature_____

Date of Birth:_____ Social Security#:_____

Witness: _____Date: _____