

NeuroCare Institute of Central Florida, P.A.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT: _____

DOB: _____ SSN: _____

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

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

PATIENT SIGNATURE

DATE

WITNESS

USE THIS SPACE ONLY IF WITHDRAWING CONSENT

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 indefinitely unless I specify an earlier expiration date here: _____(date).

DATE REVOKED

PATIENT SIGNATURE