

# NeuroCare Institute of Central Florida, P.A.

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## **AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

NOTE TO RECEIVING PARTY: This information is disclosed to you from records whose confidentiality is protected by law. Any redisclosure is strictly prohibited without 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:

\_\_\_\_\_  
\_\_\_\_\_

This information will be used for treatment.

\_\_\_\_\_  
Patient/Legal Guardian Signature Date

\_\_\_\_\_  
Relationship to Patient 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 Revoked Patient Signature