

Florida Otolaryngology Group, P.A.

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Re: _____
Print Patient's Name

Date of Birth: _____
SSN: _____

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

I authorize: _____
Name of the Facility/Person Holding the Information

Address

City, State, and Zip Code

Fax

To release from my medical records the following: **(please initial next to the applicable area)**

- _____ General medical information. (Florida statute 395.97)
- _____ Psychiatric/psychological information, alcohol and/or drug
abuse information. (Florida statute 394.459 and Federal Regulation 42CFA, Part II)
- _____ HIV test and information pertaining to these tests, or to
treatment in connection with these test results.

To: _____
Name of the Facility/Person to Receive the Information

Address

City, State, and Zip Code

Fax

For the purpose of: _____

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 for ninety (90) days unless I specify an earlier expiration date here: _____ (date).

Patient/Legal Representative's Signature

Date

Legal Representative's Relationship to the Patient

Signature of Witness

Print Name of Person Requesting Records

Phone Number of Person Requesting Records