Florida Otolaryngology Group, P.A.

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

_____ _____

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

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

_____ General medical information. (Florida statue 395.97)

_____ Psychiatric/psychological information, alcohol and/or drug abuse information. (Florida statue 394.459 and Federal Regulation 42CFA, Part II)

_____ HIV test and information pertaining to these tests or treatment in connection with these test results.

To: _____

Name of the Facility/Person to Receive the Information

_____

Address

_____

City, State, and Zip Code

_____

Fax *Phone*

For the purpose of: _____

Please allow 48-72 hours to complete your request. Patient charts older than 3 years (patient has not been seen for 3 years) may take additional processing time.

- □ I will pick up my records.
- □ Mail the records to the address listed above.
- □ Fax the records to the fax number listed above.

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). This authorization will remain in effect for ninety (90) days unless I specify an earlier expiration 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*