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## AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

J 1	DOB
( ) All general medical rec	ords, including HIV/AIDS, substance abuse, and psychiatric records.
( ) Limited records (i.e. lab	results, EKG, MRI, X-rays, CT, etc.)
То:	
	PROHIBITION ON RE-DISCLOSURE
of the person to who such in HIV/AIDS, substance abuse authorization for the release  In the event these records ar	ing any further disclosures of such information without the express written consent formation pertains, or as otherwise permitted by state law. With regard to so or psychiatric records; a specific written consent is required – a general of medical or other information is NOT sufficient for this purpose.  The being requested other than for the personal use of the patient or an attending per page will be assessed in accordance with Florida State Statute 395.3025.
Date signed	Signature or patient or authorized representative
Authorized Representative:	( ) Parent ( ) Surviving Spouse
	( ) Legal Guardian/Administrator/Executor*
*If Legal Guardian, Admini	strator, or Executor, legal proof of this status must accompany this authorization.
The patient or authorized repsubmitting a written request	presentative may revoke this authorization at any time after it is signed by to the facility.