AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS TO SFN

I, _____, D/O/B _____,
(Patient Name)

hereby authorize _____
(Organization)

to release copies of medical records and other records concerning my treatment, including but not limited to, information concerning drug abuse or drug related conditions, alcoholism, psychological and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions or sexual preference, or permit review of the same.

( ) Other _____

Exclusions _____

The above information is to be released to:

South Florida Neurosurgery
5503 South Congress Avenue – Suite 204
Atlantis, FL 33462
Phone: (561) 410-5110 Fax: (561) 328-3911

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by law.

I understand this authorization may be revoked ay any time except to the extent actions have been taken prior to revocation. This consent will expire in sixty (60) days after the date below.

I acknowledge that I have read and fully understand this authorization as it applies to me.

_____ _____
Date Signature of Patient

_____ _____
Other person legally authorized to give consent Relationship to Patient