AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

☐ 2940 Maguire Road, Suite 200, Ocoee, Florida 34761
☐ 2105 Hartwood Marsh Road, Suite 3, Clermont, Florida 34711
Phone: 321-581-9065 Fax: 321-348-5827
www.PremierFSM.com

Patients name: _____ Date of birth: _____ / _____ / _____

Address: _____

E-mail: _____ Phone: _____

☐ Release of information to	☐ Request of information from
Facility:	Facility:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Please include the following:

_____ :STAT
_____ :Progress notes/HPI/H&P
_____ :Radiology Exams
_____ :All Diagnostic Results
_____ :Complete Medical Record
_____ :Pathology Reports
_____ :Immunization Records
_____ :ER/Hospital

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy Laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This consent form may be revoked in writing and otherwise expires five years from the date listed below.
**Note: If these records obtain any information from previous providers, or information about cancer diagnosis, drug/alcohol abuse, sexually transmitted diseases, HIV/ AIDS, and mental health you are hereby authorizing disclosure of this information.

_____

Patient or Parent/Guardian Signature Date