AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____

Date of Birth: _____ SS#: _____

Patient's Address: Phone #_____

_____

_____

The undersigned authorize and/or request Affordable Care Clinics to: ❑

OBTAIN FROM:

❑ RELEASE TO:

Person/Organization Name: _____

Address: _____

Phone/Fax: _____

Please DO NOT release the following:

_____

_____

- Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment, and/or examination related to mental health care, drug and/or alcohol use, HIV/AIDS testing, and sexually transmitted diseases.
- By signing this release, I understand that this authorization will remain in effect for 90 days or until revoked in writing.
- I understand that state law prohibits the re-disclosure of the information disclosed to the person/entities listed above without my further authorization, but that Affordable Care Clinics cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.
- I hereby release Affordable Care Clinics and the employees of Affordable Care Clinics from any liability that may arise from the release of information as I have directed.

X_____ _____
SIGNATURE DATE

X _____ _____
EMPOWERED REPRESENTATIVE/ GUARDIAN DATE

IF THE RECORDS ARE MORE THAN 10 PAGES, KINDLY MAIL TO FOLLOWING LOCATIONS: (Circle Location)

Avalon Park
14807 E. Colonial Dr., Ste. 112
Orlando, FL 32826
Fax Number: (713)-489-9352
Phone: (407) 917-2253

Rockledge-Viera
835 Executive Lane, #130
Rockledge, FL 32955
Fax Number: (713)-489-9352
Phone: (407) 917-2253

Boca Raton
9045 Fontana Blvd., #113
Boca Raton, FL 33434
Fax Number: (713)-489-9352
Phone: (407) 917-2253