Florida Compassionate Care Centers, LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI Mo/Day/Yr

1) I authorize the use or disclosure of the above-named patient's health information as described below.
2) The following individual or organization is authorized to make the disclosure:
   Name of Person, Provider, or Facility: _____
   Address: _____
   Phone w/ area code: _____
   Fax w/ area code: _____
3) Please release all information regarding the following;
   - ☐ Problem List
   - ☐ Medication List
   - ☐ List of Allergies
   - ☐ Most recent history and physical
   - ☐ Most recent hospital admission/discharge summary
   - ☐ Laboratory results
   - ☐ Radiology/Imaging Reports
   - ☐ Consult Notes
   - ☐ Entire Record
   - ☐ Other _____
   - ☐ Alcohol or Drug Use/Abuse Treatment Initial _____ Date _____

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated the information, if such information exists, cannot be released or discussed.

- ☐ Alcohol or Drug Use/Abuse Treatment Initial _____ Date _____
- ☐ Mental Health Treatment Initial _____ Date _____
- ☐ HIV Status or Treatment Initial _____ Date _____

4) This information may be released to and used by the following organization:
   Atitlan Wellness, LLC dba Florida Compassionate Care Centers
   PH: 386-872-3800 FAX: 386-202-1228
   279 South Yonge Street
   Ormond Beach, Florida 32174
5) I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the office staff in person or by U.S. Mail. I understand the revocation will not apply to information that has already been released in response to the authorization. This authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, the authorization will expire in six (6) months.
6) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
7) If I have questions about disclosure of my health information, I will assure all of my questions are answered prior to signing this release.

_____ Date: _____
Patient Signature

_____ Date: _____
Witness Signature

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