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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient name:________________________________ **SSN:**____________________

Date of Birth:_______________

I authorize: Dr. Luis A. Ghiglino

PLEASE CHECK ONE OF THE FOLLOWING AND INCLUDE NAMES,ADDRESSES AND TELEPHONE NUMBER

To obtain from:____
____

To release to:____
____

INFORMATION TO BE RELEASED:12 months of records will be copied unless otherwise Indicated

(please circle Yes or No for each category listed)

Y N Medical History	Y N Operative Report	Y N Medical Record
Y N Treatment or Tests	Y N Laboratory Report	Y N Consultations
Y N Pathology Report	Y N Discharge Summary	Y N X-ray Reports
Y N Social History	Y N Radiation Summary	Y N Other(specify)______
Y N Mental Health Record	Y N Substance Abuse Record	Y N HIV/AIDS Record
Y N Sexual Assault Record	Y N Child Abuse Record	Y N Minor's Report
Y N Venereal Disease Record	Y N Medical Examiners Report	

The information is needed for the following purpose(s):____________________________________
____

I understand that these records are of a privileged and confidential status. I waive that status for the purpose contained within this authorization. I agree to hold Dr. Luis A. Ghiglino harmless from any and all costs, liability and damages of any nature whatsoever, including attorney fee resulting directly or indirectly from Dr. Luis A. Ghiglino release of these records pursuant to this consent. This authorization expires ninety(90) days following date of signature without my express revocation.

I acknowledge that I have read and understand this authorization and its content.

______________________________	______________________________
Signature of Patient Date	Relation to patient if signed by guardian
______________________________	______________________________
Witness Date	reason Patient is unable to sign

Prohibition of Redisclosure. The information is being disclosed to you from records whose confidentiality is protected by state laws, specifically Florida Statutes 395.302, 455.667 and 394.459. State laws prohibit you from any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A general authorization is not sufficient for this purpose.