Negroski Neurology & M.S. Center of Sarasota
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Authorization to Release Protected Health Information

Patient Name: _____ _____ _____ Date of Birth: _____
Last *First* *MI*

I HEREBY AUTHORIZE THE FOLLOWING ORGANIZATION TO RELEASE MY MEDICAL RECORDS:

Name	Phone #	Fax#

All sensitive information regarding Alcohol and/or Drug Abuse, Behavioral Health & HIV <u>will be released</u> unless you restrict by initialing to the right.	Alcohol and/or Drug Abuse Information: _____ Behavioral Health Information: _____ HIV/AIDS related information: _____

I AUTHORIZE THE ABOVE LISTED MEDICAL RECORDS TO BE RELEASED TO THE FOLLOWING:

Practice / Physician Name	Phone #	Fax#

I am entitled to receive a copy of the completed authorization form upon request. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby recognize that I have read and fully understand the above statements as they apply to me.

Signature of Patient _____ Date _____

Signature of Parent/Guardian or Personal Representative *(Attach proper documentation)* _____ Date _____

Medical Records Fax Number: 941-487-2170