DAVID W. MALKA, M.D., P.A.
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The MIND
MALKA INSTITUTE OF NEUROSCIENCE AND DISEASE

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: David W. Malka, M.D., P.A., dba The M.I.N.D. - Malka Institute of Neuroscience and Disease Phone #: 727-442-6463

Address: 7539 Medical Dr., Hudson, FL 34667

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

METHOD OF DISCLOSURE:

☐ **Pick up at Clinic/Facility (fee may apply: $1/pg for first 25 pages, $0.25 for each page after)**

☐ **Address: _____ (fee may apply: $1/pg for first 25 pages, $0.25 for each page after)**

☐ **Fax #: _____ (fee may apply: $10 flat electronic records fee)**

☐ **Email Address: (please note that emailing may not be a secured method of communication) (fee may apply: $10 flat fee)**

_____

INFORMATION TO BE DISCLOSED: (Please select "Other: (specify)" and write "all records" if all records are needed)

☐ General Medical Record(s), including STD and TB ☐ Progress Notes ☐ History and Physical Results

☐ Immunizations ☐ Family Planning ☐ Prenatal Records ☐ Consultations

☐ Diagnostic Test Reports (Specify Type of test(s) _____

☐ Other: (specify) _____

I specifically authorize release of information relating to:

☐ HIV test results for non-treatment purposes ☐ Substance Abuse Service Provider Client Records

☐ Psychiatric, Psychological or Psychotherapeutic notes ☐ Early Intervention ☐ WIC

PURPOSE OF DISCLOSURE:

☐ Continuity of Care ☐ Personal Use ☐ Other (specify)_____

EXPIRATION DATE: I understand that if I fail to specify an expiration date or event, this authorization will only expire upon written request to the office and will automatically renew after 12 months.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations and hereby release David W. Malka, M.D., P.A. and its associates from any liabilities therein.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form but recognize that not doing so may restrict my doctors from obtaining necessary records for continuity of care.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

Patient Name:_____

DOB: _____

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Printed Name Legal Representative's Relationship to Patient

_____ _____

Witness (optional) Date

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration). Failure to do so, including an assumption it has already been provided, may result in delay or denial of release of information.