**CHRISTOPHER, MD. & ASSOCIATES**

**131 Redstone Avenue, Suite 107, Crestview, FL 32539**

**Ph: 850-682-6320 Fax: 850-682-6339**

**Authorization for Release of Information**

Instructions: Fill in all blanks for required information and sign release

Patient: NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider: NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MD releasing data) ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information Requested:

* Complete Records/dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Labs/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_
* EKG/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* H&P Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Immunization Records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Radiology/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other/Specifics:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send Information to: Christopher MD and Associates

131 E Redstone Ave Ste 107

Crestview FL 32539

850-682-6320 (p), 850-682-6339 (f)

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to: (check all that apply)

* Substance Abuse
* HIV or AIDS related testing and treatment
* Mental Health

This authorization is good for **one year from the date of signature.** I understand that I may revoke this authorization at any time by giving written notice to CMDA. I understand that I have the right to inspect t the information and data disclosed under proper notification and under appropriate conditions. This statement is made and the authorization is binding, controlling, and I understand that they take precedence over statements made in the CMDA Privacy Practices.

Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_