Authorization for Release of Information (ROI)

I hereby give my permission to:____

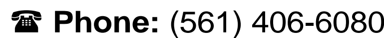
to release a copy of the specific information/documents listed:__________________________

____

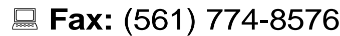
MedFlorida Medical Centers

3889 Military Trail Ste. 104

Jupiter, FL 33458



☎ **Phone:** (561) 406-6080



Fax: (561) 774-8576

For the purpose(s) of *Alcohol & Drug abuse clients only*:
This is ___ a single disclosure or __ a continuing disclosure for 90 days.*(please check one)*
Date on which consent is given:___________________
Release Expiration Date: ________________________
(Consent is subject to revocation at any time.)

☐ Drug Abuse ☐ Psychiatric/Psychological ☐ HIV/AIDS ☐ Alcohol Abuse

___ *(Initial Here)* I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

NAME OF PATIENT:____

DATE OF BIRTH: ____

SIGNATURE OF PATIENT: ______________________________________

SIGNATURE OF GUARDIAN:_____________________________________

SIGNATURE OF WITNESS:______________________________________

To Receiving Agency: Prohibition of Redisclosure! This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.