AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Pursuant to The Health Insurance Portability and Accountability Act (H.I.P.A.A.), 45 C.F.R. 164.508, and Florida Statute 456.057, the undersigned knowingly and voluntarily agrees to the release of any and all protected health information for any and all purposes regardless of whether any particular purpose is mentioned, including but not limited to all prescriptions including drug, dosage, and quantity; all notes regarding past, present, or future treatment or examination; any record or document considered a medical record under Florida or federal law; and any other document pertaining to the treatment or follow-up treatment of the undersigned at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes that a criminal violation of federal or Florida law has occurred. The undersigned further knowingly and voluntarily agrees to waive any doctor-patient privilege and any information protected by such privilege, at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes that a criminal violation of federal or Florida law has occurred. The undersigned acknowledges that no provision for treatment, payment, enrollment in a health plan, or eligibility for benefits is a condition of this authorization. The undersigned understands that this authorization can be revoked in writing at any time unless the covered entity has taken action in reliance thereon. The undersigned understands that any released information pursuant to this authorization may be re-disclosed by the recipient and thus no longer protected under state or federal law. By signing this authorization the undersigned affirms that a signed copy of this authorization has been provided to the undersigned and understands that a signed copy of this authorization is available at any time in the future, upon request.

_____

Printed Name of patient

_____

Signature of the patient

_____

Date

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Pursuant to The Health Insurance Portability and Accountability Act (H.I.P.A.A.), 45 C.F.R. 164.508, and Florida Statute 456.057, the undersigned knowingly and voluntarily agrees to the release of any and all protected health information for any and all purposes regardless of whether any particular purpose is mentioned, including but not limited to all prescriptions including drug, dosage, and quantity; all notes regarding past, present, or future treatment; any document considered a medical or patient record under Florida or federal law including any record related to any physical or mental examination or the administration of treatment or prescribing of legend or controlled drugs including X rays and insurance information; any document or communication in any form required to be submitted to the Department of Health or the Board of Medicine, and any other document pertaining to the treatment of the undersigned at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes or has reason to believe that a criminal violation of federal or Florida law has occurred.

The undersigned further knowingly and voluntarily agrees to waive any doctor-patient privilege and any confidential information protected by such privilege including any information disclosed to a health care practitioner by a patient in the course of the care and treatment of such patient, at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes or has reason to believe that a criminal violation of federal or Florida law has occurred. The undersigned further authorizes any record owner, doctor, health care practitioner, or record custodian of any record pertaining to the undersigned to disclose, release, or discuss any confidential information regarding any information obtained from the patient in the course of the care and treatment of such patient or any other protected health information.

The undersigned acknowledges that no provision for treatment, payment, enrollment in a health plan, or eligibility for benefits is a condition of this authorization. The undersigned understands that this authorization can be revoked in writing at any time unless the covered entity has taken action in reliance thereon. The undersigned understands that any released information pursuant to this authorization may be re-disclosed by the recipient and thus no longer protected under state or federal law. By signing this authorization the undersigned affirms that a signed copy of this authorization has been provided to the undersigned and understands that a signed copy of this authorization is available at any time in the future, upon request.

_____
Printed name of patient

_____
Signature of the patient

_____
Date

_____
Printed name of parent or legal guardian
(If patient is a juvenile)

_____
Signature of parent or legal guardian
(If patient is a juvenile)

_____
Date