Greater Orlando Psychiatric Associates, PA

1417 N Semoran Blvd, Suite 203, Orlando, FL 32807
Tel: (407) 206-1106 Fax: (407)206-1112

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby authorize Greater Orlando Psychiatric Associates, P.A. to:
□ **RELEASE** and/or □ **OBTAIN** information via mail, courier or facsimile transmittal to/from:

PERSON/ORGANIZATION: _____

ADDRESS:_____

CITY/STATE/ZIP:_____

PHONE: _____ FAX:_____

The request specifically includes the following:

□ Summary (Specify inclusions and exclusions) _____
□ Release Chart Entirely
□ All notes is chart ranging from _____ to _____
□ Lab Reports
□ Authorization for communication between Greater Orlando Psychiatric Associates, P.A. and _____ regarding all aspects of my treatment, diagnosis, and prognosis.
□ Forms:_____

For the purpose of:

□ Continuing Care □ Personal □ Other: _____

NOTICE TO PATIENT AND RECIPIENT OF RECORDS

I understand that this form may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data. I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. If I do not revoke this authorization, it will automatically expire in 365 days unless otherwise noted.

_____ _____/_____/_____
Patient Name (Please Print) Patient Date of Birth

_____ _____/_____/_____
Signature - Patient, Custodial Parent, Guardian or P.O.A. Date Signed/Time

_____ _____/_____/_____
Witness name and Signature Date Signed/Time

This information has been disclosed to you from records protected by Federal confidentiality rules Florida Statutes 394-459, 397.501, and/or 90.503 and 42 Code of Federal Regulations (42 CFR). This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Information (Privacy Standards) 45 CFR, 160 & 164, and all federal regulations and interpretative guidelines promulgated there under. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and Florida Statutes 394-459, 397.501, and/or 90.503. A general authorization for the release of medical or other information is NOT sufficient for this purpose.