South Palm
Family Center

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Port St Lucie, FL 34952
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Social Security: _____-___-_____ Phone Number: _____ Work Number: _____

I do hereby authorize _____to release: DISCHARGE SUMMARY, HISTORY & PHYSICAL, PROGRESS NOTES, OPERATIVE NOTES, PATHOLOGICAL REPORTS, LABORATORY REPORTS, RADIOLOGY REPORTS, EKG/ECG/CARDIAC CATH, EMERGENCY REPORTS, AND/OR OTHER

PURPOSE OF DISCLOSURE:

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from the date of the signature. I understand that I may cancel this request with written notification but will NOT affect any information of cancellation. I understand that the information used or disclosed may be subjected to re-disclosure by the person or class of persons or facility receiving it and would then longer be protected by FEDERAL regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

Individual or Guardian or Personal Representative (Please sign): _____

Today's Date: _____