Stoneybrook Family Medicine Group
16106 Marsh Road, Suite 102
Winter Garden, FL 34787
p 407.347.0600
f 407. 347.0599

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION TO STONEYBROOK FAMILY MEDICINE GROUP

I, _____ hereby authorize the use or disclosure
Print Patient/Legal Representative or Parent/Legal Guardian Name

of the individually identifiable health information of _____
Print Patient Name Date of Birth

Person/Organization authorized to release the information **to:** Stoneybrook Family Medicine Group via

FAX: 407.347.0600

_____

_____

_____

Please INITIAL items to be released:

_____ All Medical Records _____ All Diagnostic Test Results _____ Pathology/Operative Reports _____ Radiology Only
_____ Consultation/Progress Notes _____ Labs Only _____ Other (Specify) _____

In addition, please INITIAL by each specific item (if applicable):

_____ Mental Health _____ HIV Testing _____ Genetic Counseling/Testing Information _____ Drug and/ or Alcohol _____ AIDS Information
_____ STD/Communicable Diseases _____ Domestic Violence

This authorization expires on: _____ (I understand that if I fail to specify an expiration date that this authorization will expire in one year).

I understand that this authorization is revocable upon written notice to the office where the original authorization was retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, domestic violence, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I understand that I may select the information from the list above to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my record carries with it the potential for an unauthorized re-disclosure of my health information.

X_____ _____
Patient/Legal Representative or Parent/Legal Guardian SIGNATURE REQUIRED Date of Authorization

_____ _____ _____
Patient Date of Birth Social Security Number Primary Phone Number

Address City State Zip Code