910 Royce Street Pensacola, FL 32503 • 850.791.6010 • 850.444.4992

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, ____, DOB: _____________ , hereby grant authorization to ____and its employees, to disclose the following protected health information to

____:

Information to be disclosed:

1. _____________________________________
2. _____________________________________
3. _____________________________________

I understand that this Authorization is voluntary and that the information to be disclosed may be protected by law. This protected health information will be used solely for the purpose of ____. I understand that the information disclosed may be re-disclosed and utilized by the recipient without my knowledge or consent and therefore the privacy of my personal and health information will no longer be protected by federal privacy regulations.

I acknowledge that I have read and understand this Authorization and that, by signing this form I am authorizing the use and/or disclosure of my confidential protected health information.

Patient Signature ___________________________ Date: ______________

Witness: _________________________________ Date: ______________