

**Drs. Dolgin, Donnelly, Davis, Vincent, and Anderson**

4714 N. Armenia, Suite 200, Tampa, FL 33603  
Phone (813) 872-8794 Fax (813) 879-1652

4655 Keysville Avenue, Spring Hill, FL 34608  
Phone (352) 688-0800 Fax (813) 688-0468

**RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ SS# \_\_\_\_\_  
(Patient's Name)

Date of Birth \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Authorize \_\_\_\_\_  
(Name of Who Is to Release Information)

To Release Information from my Medical Records requested medical information, including:

- Office Notes, Lab Work, Testing & X-rays
- HIV Antibody Test results/AIDS records
- Other \_\_\_\_\_
- Psychotherapy Notes/Drugs and Alcohol
- Communicable Disease (Hepatitis, etc.)

To: \_\_\_\_\_ (Recipient of Record)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The information Will Be Used for the Following Purpose:

- Continued Medical Care \_\_\_\_\_ Insurance \_\_\_\_\_ Legal Follow-Up \_\_\_\_\_
- Personal Information \_\_\_\_\_ Disability \_\_\_\_\_ Other \_\_\_\_\_

The information to be released also shall include:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II) prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient Representative Signature

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

**RELEASE OF CONFIDENTIAL INFORMATION**