Assistant Clinical Professor of Neurology
Florida State University College of Medicine

MEDICAL
Team Neurologist
Florida Panthers

Florida Center
for **Headache & Sports Neurology**

HIPAA COMPLIANT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

Social Security #: _____ ACCT#_____

I request and authorize medical records from the following facility:

_____
_____
_____

I authorize to release information to the following person:

Name/Relationship: _____

To release healthcare information of the patient named above to:
FLORIDA CENTER FOR HEADACHES & SPORTS NEUROLOGY
10377 SOUTH US HWY 1
SUITE 104
PORT ST LUCIE, FL 34952
(PHONE) 772-337-7272
(FAX) 772-337-7734

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

_____

All healthcare information:

_____

Other: _____

CONDITIONS OF AUTHORIZATION:
I MAY REVOKE THIS AUTHORIZATION IN WRITING. IF I DO, IT WILL NOT AFFECT ANY PREVIOUS ACTIONS ALREADY TAKEN IN RELIANCE UPON MY AUTHORIZATION. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF ITS PURPOSE WAS TO OBTAIN INSURANCE. I MAY REVOKE THIS AUTHORIZATION BY WRITING A LETTER AND MAILING IT CERTIFIED MAIL, RETURN RECEIPT REQUESTED, TO THE PRIVACY OFFICEER AT THE HEALTHCARE PROVIDER LISTED ABOVE. INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.
THIS AUTHORIZATION IS VALID FOR 90 DAYS FOR THE RELEASE OF INFORMATION AS INDICATED ABOVE. ONLY RECORDS FROM THIS FACILITY CAN LEGALLY BE RELEASED. ANY RECORDS FROM OTHER PHYSICIANS MUST BE OBTAINED FROM THEM.

_____ _____
Patient Signature & Date **Guardian Signature & Date**

_____
Witness Signature & Date