



**AUTHORIZATION FOR RELEASE OF PATIENT  
INFORMATION**

To: Any and All Treating Health Care Practitioners or Facilities:

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes. This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation.

By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances at the Department's discretion.

**A photocopy of this document is as sufficient as the original.**

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Authorized Person Other than Patient (Print): \_\_\_\_\_

Signature of Authorized Person Other than Patient: \_\_\_\_\_

Witness Name (Print): \_\_\_\_\_ Witness Signature: \_\_\_\_\_

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