ADVANCED MEDICAL OF FLORIDA
1857 GULF TO BAY BLVD., CLEARWATER, FL 33765

727-408-5222
FAX: 727-408-5252

MEDICAL RECORD RELEASE AUTHORIZATION

PATIENTS NAME	BIRTHDATE
SOCIAL SECURITY	ACCT NUMBER

I, (THE UNDERSIGNED) AUTHORIZE

PROVIDER/FACILITY NAME
ADDRESS & PHONE NUMBER

TO RELEASE INFORMATION FROM THE RECORD(S) OF THE PATIENT SHOWN ABOVE TO :

Advanced Medical of Florida
1857 Gulf to Bay Blvd.
Clearwater, FL 33765
Phone: 727-408-5222 Fax: 727-408-5252

1. **PURPOSE OF DISCLOSURE** – TO AID AND FACILITATE IN HEALTHCARE MANAGEMENT.
2. **INFORMATION TO BE RELEASED** – ALL MEDICAL RECORDS AND DATA, X-RAYS, DIAGNOSTIC TESTS, SURGICAL & PATHOLOGY INFORMATION AND ANY DATA THAT YOU HOLD AS CUSTODIAN OF RECORDS FOR MY MEDICAL/HEALTH MANAGEMENT.
3. **VALIDITY & REVOCATION OF THIS AUTHORIZATION** THIS AUTHORIZATION IS VALID FOR A 90 DAY PERIOD FROM DATE OF SIGNATURE AND CAN BE REVOKED BY WRITTEN NOTIFICATION TO ADVANCED MEDICAL OF FLORIDA.
4. **INITIAL ANY THAT APPLY (NO INITIALS GIVE AUTHORIZATION FOR RELEASE)**
   _____ NO, I DO NOT AUTHORIZE YOU TO RELEASE INFORMATION CONCERNING MENTAL HEALTH PROBLEMS SUCH AS PHOBIAS, DEPRESSION, ANXIETY, ATTENTION DEFICIT DISORDERS, ETC.
   _____ NO, I DO NOT AUTHORIZE YOU TO RELEASE ANY AND ALL MEDICAL RECORDS IN YOUR POSSESSION RELATING TO A DIAGNOSIS OR TREATMENT OF HIV OR AIDS OR SEXUAL TRANSMITTED DISEASES OR ANY AILMENT RELATED THERETO.
   _____ NO, I DO NOT AUTHORIZE YOU TO RELEASE INFORMATION CONCERNING ALCOHOL OR DRUG ABUSE TREATMENT.
5. **PHOTOCOPY** OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL LAW.

SIGNATURE	DATE
PRINT NAME	RELATIONSHIP TO PATIENT

PATIENT OR PERSONAL LEGAL REPRESENTATIVE (NEXT OF KIN OR LEGAL GUARDIAN TO SIGN ONLY IF PATIENT IS A MINOR. IF LEGALLY INCOMPETENT OR DECEASED DOCUMENTATION MUST BE ATTACHED SHOWING LEGAL REPRESENTATION).