Authorization

Disclosure of Health Information

ROBINSON MD
FUNCTIONAL & CONCIERGE MEDICINE

PATIENT NAME: LAST	FIRST	MIDDLE INITIAL

STREET ADDRESS:	APT #

CITY:	STATE:	ZIP:	BIRTH DATE:

HOME PHONE:	CELL PHONE:	SSN - -

PHYSICIAN ONLY:

The undersigned hereby authorizes and requests ______________________ to provide to/or receive from MD office/hospital:

STACEY J. ROBINSON, MD

200 Central Avenue, Suite 810 • Saint Petersburg, Florida 33701
Telephone: 727-329-8859 • Fax: 727-825.0330

Identity of Third Party or Authorized Representative/Name of Health Care Facility

PHYSICIAN ONLY: Below - Please check next to each type of information to be disclosed (include dates where indicated)

___ Most recent history and physical or specific date(s) ____________________

___ Most recent discharge summary or specific date(s) ____________________

___ Consultation reports, specify types or date(s) ____________________

___ Laboratory results, specify types or date(s) ____________________

___ Other diagnostic testing results, specify types or date(s) ____________________

___ Entire record, specify date ____________________

___ Other, specify ____________________

___ No limitation placed on dates, history of illness, or diagnostic and therapeutic information for treatment for alcohol and drug abuse as protected by Federal Regulation 42CFR, Part II; psychiatric/psychological information and HIV/AIDS related information including testing per FS 90.503.381.004 and 394.459

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my revocation to the health information management department or mail to the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If, I fail to specify an expiration date, event or condition, **this authorization will expire in 1 year.**

Signature of Patient/Legal Representative: ____________________

Signature of Witness: ____________________

If signed by Legal Representative, Relationship to Patient: ____________________ **Date:** __________