AUTHORIZATION

DISCLOSURE OF HEALTH INFORMATION

FUNCTIONAL & CONCIERGE MEDICINE

PATIENT NAME: LAST:	FIRST:	MIDDLE INITIAL:
BIRTH DATE:	STREET ADDRESS:	APT#
CITY:	STATE:	ZIP:
PHONE:		

PHYSICIAN ONLY

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

STACEY ROBINSON, MD or EMILY BURK, DO
100 2nd Ave. S • 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

- ☐ 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 dates _____
- ☐ Other _____
- ☐ 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 HIVIAIDS 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: _____