

Authorization for Release of Medical Information

PLEASE COMPLETE ALL BLANK AREAS MARKED X

TO: _____ Date: **X** _____
Regarding Patient: **X** _____ Date of Birth: **X** _____
(Print Name)

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including **Highly Confidential Information** which may be part of my medical record covering the period:

FROM: _____ TO: _____

These records should include:

These records are to be forwarded to: Daniel K. Hellerstein, MD
Suite 5100
1411 North Flagler Drive
West Palm Beach, Florida 33401
TEL: 561-650-0815
FAX: 561-650-0819

I understand that I may revoke this consent in writing at any time.

Witness **X** _____ Signed **X** _____

(Print Name)

(Relationship) *If other then self

Highly Confidential Information

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including **Highly Confidential Information**: the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment, and referral; (4) is about HIV/AIDS testing diagnosis or treatment; (5) is about genetic testing; (6) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; (8) is about sexual assault.

I understand that I may revoke this consent in writing at any time.

Witness **X** _____ Signed **X** _____

(Print Name)

(Relationship) *If other then self

- ❖ Note: a copy of the document which establishes legal representation of patient must be attached to this consent, i.e., power of Attorney, Court Order for Legal guardianship, etc.