AUTHORIZATION FOR DISCLOSURE / RELEASE OF PATIENT INFORMATION

I hereby authorize _____

_____

_____

Phone: _____

Fax: _____

To disclose / release the complete health records of the patient identified below to:

Sinai Internal Medicine Specialists, PA
910 Old Camp Road, Suite 144
The Villages, FL 32162
352-753-2224 Fax: 352-753-0833

If Records exceed 10 pages, we request that they be mailed NOT Faxed.

DR: _____

PATIENT
NAME: _____ DOB: _____ SS# _____

PHONE NO#: _____

I understand this disclosure may include information relating to any of the following: AIDS, HIV, Psychiatric care, and treatment and / or tests relating to alcohol and / or substance abuse. *The purpose of this disclosure is for continuing medical treatment.*

I understand this authorization may be revoked in writing at any time, except to the extent that the action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire ONE YEAR after the date signed, or the following the event of
Condition: _____

_____

The facility, its employees, officers and physicians are hereby released for any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____
Signature of Patient or Legal Representative *Date* *Relationship to Patient*

_____ _____
Signature of Witness *Date*