OSLER
MEDICAL

# Authorization for Release of Protected Health Information

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #:_____ Patient Acct #:_____

I hereby authorize Osler Medical to disclose Protected Health Information of the above named patient to:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Information authorized to release: ☐ Medical Records
☐ Billing Records

Information authorized to release for services rendered during the period from _____ to _____, to include any Federal and State protected information under Florida Statute 394.459(9) Psychiatric information, Florida Statute 397.053 and Florida Statute 396.112, Drug and/or Alcohol Abuse information and Florida Statute 381.609(2) Human Immunodeficiency Virus test results (AIDS and related conditions).

I understand that authorizing the disclosure of this protected health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of protected health information, I may contact Osler Medical's Administrator/Privacy Officer.

I understand and direct that this authorization remains in effect for six (6) months or until I revoke it in writing. I hereby release Osler Medical and its employees from any and all liability that may arise from the release of this protected health information as I have directed.

_____ _____
Signature of Patient of Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness