OSLER
MEDICAL

Authorization to Obtain Protected Health Information

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #:_____ Patient Acct #:_____

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

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 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

Please send protected health information to: **Osler Medical**
930 S. Harbor City Blvd
Melbourne FL 32901
(321) 725-5050

Attention Osler Physician:_____