AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(HIPPA Compliant: 45 CRF s.164.508)

Patient Name:___________________________________
Date of Birth__________________________

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

____
____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

__ problem list
__ list of allergies
__ most recent history and physical
__ laboratory results
__ consultation reports
__ medication list
__ immunization record
__ most recent discharge summary
__ x-ray and imaging reports
__ entire record
__ other ____
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4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization: to **Brett M. Bressler, P.A., 2707 W. Fairbanks Ave., Winter Park, FL, 32789 phone (407) 599-2002, fax (407) 599-2007.** I authorize the release of records to Brett M. Bressler, P.A. by facsimile and by U.S. Mail. The purpose of the disclosure is to provide my attorney with my medical records.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

___________________________________ ______________________
Signature of Patient or Legal Representative Date

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