MEDICAL ASSOCIATES OF BREVARD

402 N. Babcock St. Suite 102
Melbourne, FL 32935
Phone: (321) 241-6540
Fax: (321) 428-4442

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ Date of Birth: _____

Social Security #: _____ Telephone #: _____

I hereby authorize S. Jerry Pinto M.D. to release Medical Records to:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Any information, including diagnosis and medical records of any treatment or examination rendered to me during the following time period:

_____ All records

_____ The past 12 months or most resend records on file

_____From the time period _____ to _____

And include any federal and state protected information under Florida statue 394.49(9) Psychiatric information. Florida Statue 397.501, and Florida Statue 397.112 Drug and/or Alcohol abuse information and Florida Statue 381.004. FAC IOD-93.064 Human Immunodeficiency Virus Test results (HIV Testing. AIDS and related conditions)

- I understand and direct that this authorization remain in effect until I revoke the authorization in writing.
- I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA regulations.
- I release Dr. S. Jerry Pinto and his employees from any and all liability that may arise for the release of this information as I have directed.

Patient Signature: _____Date: _____
(Patient or guardian)
Relationship to patient if signed by personal representative: _____

Witness:_____ Date: _____