AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____Date of Birth: _____
Social Security Number: _____Telephone: _____
Reason for Release: _____

Release **FROM:**

Dr's Name: _____
Address: _____
City, Sate, Zip: _____

Release **TO:**

Pinsky Family and Sports Medicine Center
8045 Spyglass Hill Road
Suite 104
Melbourne, FL 32940

I herby authorize the release of information, including diagnosis and medical, surgical, laboratory, or radiological records of any treatment, examination, or test rendered to me during the period from _____to _____, to include any Federal and State protected information under Florida Statute 394456 (9) Psychiatric information, Florida Statute 381.609 (2) Human Immunodeficiency Virus test results (AIDS and related conditions).

I understand and direct that this authorization will remain in effect for six (6) months or until I revoke it in writing. I hereby release the originating office or facility and its employees from any and all liability that may rise from the release of this information as I have directed. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Signature of the patient: _____Date: _____

OR

Signature of Empowered Representative: _____

Relationship to Patient: _____Date: _____

Witness: _____Date: _____