South Florida Neurology Associates, P.A.
Diplomates, American Board of Psychiatry and Neurology

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RELEASE OF INFORMATION AUTHORIZATION FORM

I, _____, Date of Birth: _____/ _____/_____
(Patient's Name)

hereby authorize SOUTH FLORIDA NEUROLOGY ASSOCIATES to:

☐ Release protected health information to:

☐ Receive protected information from:

☐ Share protected health information with:

Name of Facility/Individual: _____

Address:_____

_____

Phone:_____Fax:_____

Records Desire: ___ Office Notes ___ Diagnostic Tests ___ Medication List
___ Labs ___ Other: _____

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It is understood:

- That the recipient of the protected health information under this authorization should not re-disclose the information without a written authorization.
- Health Care Provider will not condition the provision of care or receipt of benefits on the signing of the authorization.
- Patient will receive a copy of the completed authorization form upon request.
- Patient may revoke this authorization by requesting in writing.

This authorization expires: (choose one)___ 30 days from above date
___ 1 year from above date
___ immediately after this request is fulfilled

_____ _____
Patient's Signature Patient's Date of Birth

_____ _____
Printed Patient's Name Patient's Address

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