FLORIDA MIND HEALTH Center

4408 NW 36 Ave
Gainesville, FL 32606
(352) 448-6062

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Patient

_____ _____

First Name Last Name Date of Birth

I, the undersigned, hereby authorize the following medical providers to release my medical record and pertinent information to Florida Mind Health Center for the purpose of initiating or continuing treatment.

Psychiatrist/Pain Physician

_____ _____ _____ _____

Name Phone # City State

Psychiatrist/Pain Physician

_____ _____ _____ _____

Name Phone # City State

Psychotherapist

_____ _____ _____ _____

Name Phone # City State

Primary Care Provider

_____ _____ _____ _____

Name Phone # City State

I understand that areas of my medical record including information pertaining to mental health, drug, and/or alcohol abuse will be included unless I specify that the following areas are not be released:

_____ _____
_____ _____
_____ _____
_____ _____

Release or transfer of the specific information to any person or entity not specified herein in prohibited. This authorization shall be valid for five years, or until it is revoked in writing, or renewed. I understand that I have a right to receive a copy of this authorization upon my request. I release the above parties, Florida Mind Health Center, and Zohar Levites, ARNP, CRNA from any and all liability for exchanging this confidential information.

_____

Signature

_____ _____/_____/_____

First name Last name Date