

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize

Date of Birth: _____ Social Security Number: _____

Name of facility to release information:

to release information from my medical records including information of a psychological, psychiatric, alcohol or drug related nature to:

Trinity Health Center

1814 Wellness Lane
New Port Richey, FL 34655
Office: 727-376-6111

100 Main Street, Ste. 302
Safety Harbor, FL 34695
Office: 727-712-7091

935 Beneva Rd.N., Ste. 707
Sarasota, FL 34232
Office: 941-565-3490

Fax: 727-376-6199

This information will be used for the following purpose:
Continued Medical Care for Patient

The information to be released shall include: _____

I understand that this consent shall be valid for a period of 90 days from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

Patient's Signature

Patient Representative Signature

Date of Signature

Relationship to Patient

Witness
