AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize
(Name of Patient)

_____
(Name of Physician, Hospital, Facility, etc.)

_____
(Address)

_____ _____
(Phone #) (Fax #)

To release: medical; psychiatric; drug and/or alcohol abuse; HIV testing or AIDS information; or specifically _____ in my records to:
Emmanuel Christian Health Center (Vivian Woodard, M.D. & Courtland Munroe, M.D.
For the purpose of: continuing medical care.

I understand that this consent is revocable upon written notice to the facility, except to the extent that action by the facility has been taken in reliance on this authorization shall remain in force for a reasonable time in order to affect the purpose for which it is given.

Federal Law if present has been disclosed from records whose confidentiality protects alcohol/drug abuse information. Federal regulations (42CFR part II) prohibit making any further disclosure of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations, mental behavior, HIV testing, and/or AIDS related diagnosis is further prohibited from further disclosure by State Regulations without the specific written consent from the patient.

_____ _____
Date of Authorization Patient Signature in Full

_____ _____
Date of Birth Parent, Legal Guardian, or Authorized Representative Signature

_____ _____
Social Security Number Witness Signature

Please Mail or Fax Records to:

918 Rolling Acres Rd, Ste 1
Lady Lake, FL 32159
Tel: (352) 259-1991 Fax: (352) 259-5540