INFORMED CONSENT AND AUTHORIZATION TO RELEASE OR RECEIPT OF INFORMATION

THE UNDERSIGNED PATIENT OR LEGAL REPRESENTATIVE OF THE PATIENT, HEREBY AUTHORIZES THE RECEIPT OF RELEASE OF THE INFORMATION SPECIFIED BELOW TO THE FOLLOWING PHYSICIAN OR MENTAL HEALTH PROFESSIONAL PURSUANT TO FLORIDA STATUES 90.42, 490.32, 90.503, 456.16, 458.21 AND 394.459 (B), 381.609 (2) (F), 396.112, 397.053 AND FEDERAL LAW 42. I UNDERSTAND THAT MY RECORDS HAVE A PRIVILEGED AND CONFIDENTIAL STATUS. I AM WAIVING THAT STATUS FOR THE PURPOSE CONTAINED WITHIN THIS AUTHORIZATION.

RELEASE TO/FROM ____

____

ADDRESS CITY STATE ZIP

RELEASE TO: GERARDO P. SISON, JR., M.D. CHILD, ADOLESCENT AND ADULT PSYCHIATRY
FROM: 34650 U.S. 19 NORTH #107 PALM HARBOR, FLORIDA 34684 (727) 787-3422
FAX (727) 787-5624

SPECIFIC INFORMATION TO BE RELEASED OR RECEIVED:

MEDICAL / PHARMACOLOGICAL
PSYCHOLOGICAL TESTING
CONSULT REPORTS
PSYCHIATRIC EVALUATION
HOSPITAL ADMISSION PSYCHIATRIC EVALUATION
HOSPITAL DISCHARGE SUMMARY
OTHER: ______________________________

INFORMATION CONCERNING AIDS, HUMAN IMMUNODEFICIENCY VIRUS INFECTION, ARC, AIDS-RELATED COMPLEX AND THE PERFORMANCE OF ANY TESTS, COUNSELING AND THE RESULTS AND TREATMENT THEREOF IS / IS NOT ALSO AUTHORIZED.

A GENERAL MEDICAL AUTHORIZATION OF SUBPOENA DUCES TECUM WITHOUT A SPECIFIC AUTHORIZATION TO RELEASE PSYCHIATRIC INFORMATION MUST HAVE THIS WAIVER FROM THE PATIENT OR LEGAL REPRESENTATIVE.

PROHIBITION ON RE-DISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM THE RECORDS WHO CONFIDENTIALITY IF PROTECTED BE FEDERAL REGULATION (42 CFR PART 2) AND ANY FURTHER RE-DISCLOSURE FROM THE RECEIVING PARTY IS STRICTLY PROHIBITED.

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME UPON THE RECEIPT OF WRITTEN NOTIFICATION BUT WILL HAVE NO EFFECT OR ACTION ALREADY TAKEN. THIS AUTHORIZATION IS VALID FOR A CONTINUING DISCLOSURE. I FURTHER UNDERSTAND THAT I HAVE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THE PHYSICIAN OR MENTAL HEALTH PROFESSIONAL, NAMED HEREIN, IS RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED.

PATIENT'S NAME: ____

SOCIAL SECURITY OF PATIENT: ______________________ DATE OF BIRTH ______________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE ______________________________

WITNESS: ________________________ INFORMATION RELEASE BY: ____________________

____

TODAY'S DATE