Embracing Life WELLNESS CENTER

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AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____Patient Name:_____ DOB:____/____/____

This authorization will allow Dr. Fickey to exchange general medical as well as psychiatric/ alcohol/ drug abuse/ HIV/ and or AIDS information from my health record in accordance with Florida Statutes 394, 459, 90.503, 394.4615, 397.501 and Federal Regulations (42 CFR Part 2) with:

Please Circle one: Send To or Request From

_____
(Name of Agency/ Organization/ Professional or Individual)

_____
Address Information

_____
Telephone Number/ Fax Number

I hereby authorize the use or disclosure of my individually identifiable health/ psychiatric/ mental health information as described below. I understand that the information I authorize any person or entity to receive or collect about me may be re-disclosed and no longer protected by federal privacy regulations. I understand the office of Melissa Fickey, M.D. cannot guarantee the privacy of my records once they have been released to an outside party and shall be held harmless from any liability or negligence from the re-disclosure or release of my records.

PLEASE CHECK ALL THAT APPLY BELOW

__Physician Discharge Summary	__Psychological Evaluation	__Medical History
__History/ Physical Examination	__Psychiatric Evaluation	__Lab Results
__Consultation	__Progress Notes	__Diagnosis
__Recommendation for Treatment & Care	__Treatment Plans	__Verbal Communications
__Psychiatric Discharge Summary	__Billing Records	__Insurance Coverage Info

_____ENTIRE FILE

Other Information:_____

The purpose for the release and disclosure of this protected health information is for:

___Continuation of Care ___Coordination of Care/Treatment ___Other:_____

A general medical authorization or subpoena duces tecum without a specific authorization provided to release psychiatric/ alcohol/ drug abuse/ HIV and or AIDS information must have this waiver from the patient or his/her legally authorized representative. A copy of this authorization shall be considered as void as an original signed copy. I understand that I have a right to refuse this authorization. If I approve, I further understand that Melissa Fickey, M.D. is released from all legal liability arising from the release of the information requested. Treatment will not be conditioned on the provision of a signed authorization except as permitted by law.

Prohibition on Redisclosure:

This information has been disclosed to you from the records whose confidentiality is protected by Federal law. Any further re-disclosure is strictly prohibited. These records may be protected by Federal Regulation (42CFR Part2). This consent is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance upon it. This authorization will remain valid until written revocation of the authorization is made by the patient or patient's guardian and provided to Embracing Life Wellness Center. This authorization shall remain valid for the duration for which the patient is receiving care and treatment at Embracing Life Wellness Center. Voluntary cessation of treatment or if the patient is discharged from the practice involuntarily will terminate the validity of this release.

_____ _____
Patient Signature (If patient is over the age of 18) Date

_____ _____
Legally Authorized Representative's Signature Date

_____ _____
Witness Signature Date