AUTHORIZATION TO DISCLOSE MY HEALTH INFORMATION

To: Cynthia Davis, M.D., P.A., 779 Medical Dr. Ste. 3, Englewood, FL 34223

From: _____ Birthdate: _____
Patient's printed name

You may disclose the following information about me:
Check one
_____ My health information related to the following condition or treatment only: _____
_____ My health information for the following date: _____
_____ All my health information

Circle **include** or **exclude** for each of the following:

Include or exclude - substance abuse records
Include or exclude - HIV/AIDS records
Include or exclude - a pregnant minor's records
Include or exclude - mental health records
Include or exclude - STD records

You may disclose this information to: _____
_____

Reason for this authorization: At my request _____
Other reason: _____

This authorization ends: on _____ (date)
Or when the following event occurs: _____

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Dr. Davis and her staff based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that, once the office discloses information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient's signature Date

Cynthia Davis, M.D., P.A. Effective 10/27/2010