AUTHORIZATION TO RELEASE HEALTH INFORMATION

JOHN D. STRAUSBAUGH, D.O.

9671 GLADIOLUS DR. SUITE 109, FORT MYERS, FL. 33908

PHONE 239-362-1450 FAX 239-985-9629

Patient name_____ Date of birth_____/_____/_____

I AUTHORIZE RELEASE OF INFORMATION AS STATED BELOW:

Information to be released TO_____ or **FROM**_____ JOHN D. STRAUSBAUGH, D.O.

Doctor/Organization_____

Phone_____Fax_____

Address_____

INFORMATION TO BE RELEASED

__DISCHARGE SUMMARIES __OPERATIVE REPORTS __RADIOLOGY REPORTS __ED RECORDS
__LAB/PATH REPORTS __CLINIC NOTES

OTHER_____

PURPOSE OF RELEASE

__CONTINUING CARE __COPIES FOR OWN USE __TRANSFER TO ANOTHER PROVIDER __LEGAL
__OTHER (PLEASE SPECIFY)_____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the health information services department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90-days from the date signed below unless another date is entered here_____

SENSITIVE RECORDS MAY REQUIRE SPECIFIC PATIENT AUTHORIZATION. PLEASE CHECK THE APPLICABLE BOX BELOW TO REQUEST THE FOLLOWING RECORDS:

__MENTAL HEALTH __HIV/AIDS __ALCOHOL/DRUG __SEXUALLY TRANSMITTED DISEASES

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

Signature_____**Date**_____**Relationship**_____

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS

Minor: A minor patient signature is required to release the following information: 1) information related to reproductive care such as birth control, pregnancy-related services and sexually transmitted disease, including hiv/aids (age 14 and older): 2)substance abuse and mental health treatment (age 13 and older).

Minor signature_____**Date**_____