Jose F. Polanco, M.D., P.A.

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First Name: ______________________ Last Name: ______________________

Date of Birth: ___________________ SS#______________________________

INFORMATION TO BE RELEASED FOR THE PURPOSE OF:

_____ Continuous Care _____Consults _____Treatment Planning

_____New Primary _______Legal _____Psychological Evaluation

***NO CD'S PLEASE!**

Previous Doctors:

Name: ______________________ Specialty: ___________________ Phone #: ___________________ Fax #: ___________________

Name: ______________________ Specialty: ___________________ Phone #: ___________________ Fax #: ___________________

Name: ______________________ Specialty: ___________________ Phone #: ___________________ Fax #: ___________________

Name: ______________________ Specialty: ___________________ Phone #: ___________________ Fax #: ___________________

TYPE OF INFORMATION TO BE RELEASED:

_____Admin/Discharge Summary _____History & Physicals _____ Psychological Evaluation
_____Treatment Planning _____Labs & Diagnostics _____Progress Note
_____Psychiatric Evaluation _____Medication Summary _____All Medical Records

Notice of Prohibition on Disclosure: This information has been disclosed to you from records protected by federal confidentiality regulations (42 CFR Part 2) and Florida Statutes. This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2) and the Florida Statutes (394.459,3.96.053,381.609,455.2416,90.503,90.242). The Federal Rules and State Statutes prohibit you from making any additional disclosure of this information without the specific written consent of this person to which you belong or as permitted by 42 CFR Part 2. (394.459.3.96.053.381.609.455.2416.90.503.90.242). The Federal Rules and State Statutes prohibit you from making any additional disclosure of this information without the specific written consent of this person to whom you belong or as permitted by 42 CFR Part 2.

Recognition of Understanding:

✓I understand that I have the right to refuse this authorization. If I approve, the individuals mentioned above are released from any legal responsibility that may arise from the disclosure of the requested information.

✓This will authorize José F. Polanco, M.D., P.A. to release or receive protected health information as well as psychological, psychiatric, alcohol / drug / HIV and / or AIDS abuse from my health records in accordance with the Florida Statutes and the Florida and Federal Statutes and HIPAA Rules and Regulations.

_________________________________ _________________________________

Patient Signature Date