Atlantic Psychiatric CENTER

❒ 2123 Franklin Dr. NE
Palm Bay, FL 32905
(321) 724-1614
FAX (321) 722-3590

❒ 4185 South US1, Unit 102
Rockledge, FL 32955
(321) 638-0027
FAX (321) 638-0115

❒ 1351 Bedford Drive
Melbourne, FL 32940
(321) 757-6799
FAX (321) 757-6792

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I, _____ hereby **authorize**

(Name of DR/Facility) _____

Address _____

Phone _____ Fax _____

to release information/medical records

To: _____

() use the following protected health information
() disclose the following protected health information

This protected health information is to be used for or disclosed for the following **purpose** _____

This information to be used or disclosed is described by the following descriptors (such as date and **type of service and detail to be released)** _____

This authorization shall remain in effect until:
() completion of treatment
() until the following date _____ at which the authorization will expire

I have been informed that I have the right and may exercise that right in writing at any time to revoke this authorization. I am in receipt of and understand my rights set forth in the notice of privacy practices.

According to Federal law, I do not give Atlantic Psychiatric Centers, Inc authorization to make the following disclosures

_____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I further understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the privacy rule or if conditioning is permitted by the privacy rule, I have been informed of and understand the consequences of refusing to sign the authorization. the statements included in this authorization are binding on Atlantic Psychiatric Centers, Inc

Patient or Personal representative:

Signature _____ Date _____

Printed name _____ DOB _____

Description of Personal representative's authority: _____

Witness: _____ Date _____